MILITARY CONSTRUCTION AND VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2009

THURSDAY, APRIL 10, 2008

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 2:08 p.m., in room SD–124, Dirksen Senate Office Building, Hon. Tim Johnson (chairman) presiding.

Present: Senators Johnson, Landrieu, Murray, Reed, Hutchison, Craig, and Allard.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. JAMES B. PEAKE, M.D., SECRETARY

ACCOMPANIED BY:

PAUL HUTTER, GENERAL COUNSEL
ADMIRAL PAT DUNNE, ACTING ASSISTANT SECRETARY FOR BENEFITS
DR. MIKE KUSSMAN, UNDER SECRETARY FOR HEALTH
BOB HOWARD, ASSISTANT SECRETARY FOR INFORMATION TECHNOLOGY
WILLIAM TUERK, UNDER SECRETARY FOR MEMORIAL AFFAIRS
BOB HENKE, ASSISTANT SECRETARY FOR MANAGEMENT

OPENING STATEMENT OF SENATOR TIM JOHNSON

Senator JOHNSON. The hearing will come to order. Mr. Secretary, thank you for appearing before the subcommittee to discuss the President's 2009 budget request for the Department of Veterans Affairs.

We welcome you and your associates and we look forward to your testimony.

Over the past several years, Congress has provided the VA with substantial increases over the president's annual budget requests to address some of the most pressing unmet needs facing our country's vets. Last year, Congress provided $3.7 billion above the president's budget request for the department. The bulk of this funding was dedicated to the Veterans Health Administration to provide medical care to vets.

However, we also provided needed increases for hospital construction, benefits claims processors, and grants to correct deficiencies at State vet homes and cemeteries.

All of these increases were designed to put the VA on a glide path to providing not just high-quality services but high-quality

services in a timely manner and in facilities befitting those who have served this country.

This year, the president's discretionary budget request for the VA totals $44.8 billion. This is a $1.7 billion increase, a mere 3.8 percent over the 2008 enacted level.

While I understand that record budget deficits and a teetering economy are going to require belt tightening, I am nevertheless deeply concerned that this level of funding may not be sufficient to continue to modernize the VA system while providing timely services.

At a time when we should be increasing funding for research in complex combat-related injuries, the budget cuts funding for medical research. Additionally, the budget cuts over $788 million for the construction accounts. This is coming at a time when there is already a backlog of construction projects on the books and when many new construction projects are pending before the VA.

Mr. Secretary, I fear that we are seeing only the tip of the iceberg in terms of the challenges the VA will be facing in years to come. This subcommittee stands ready to help in every way we can to ensure that the VA meets those challenges.

I look forward to hearing the testimony and working with you as the process moves forward.

I will now turn to Senator Hutchison for her opening statement.

STATEMENT OF SENATOR KAY BAILEY HUTCHISON

Senator HUTCHISON. Thank you very much, Mr. Chairman, and I want to say how much I appreciate, Secretary Peake, your first official visit as the Secretary. I also want to say that I have been so pleased to work so closely with you already in such a short time. I have worked with both you and Secretary Kussman before and you have been so attentive to the questions that we've asked. I appreciate it.

Having been down to the Rio Grande Valley in Texas and looking at the facilities that are going to go in there, it has been a substantial improvement in veterans care, and I want to say that I wrote you a letter yesterday regarding the El Paso Veterans Center which, as you know, came in with the lowest grade given in the books of all the veterans facilities. You have already responded and I appreciate that you are now on top of that because not only do we have a number of veterans in El Paso, but we have a whole lot more who will be veterans in the future with the 30,000 plus-up that we're going to have at Fort Bliss.

I thank you for that.

I have just a couple of points and then I want to submit my full statement in the record.

There are two areas where the VA has responded and which we must continue to assure that it does respond. The first is in the injuries that we are seeing in this war, the present new veterans, and that would be the posttraumatic stress syndrome and the mental health disorders. That program has now under our leadership grown to nearly $4 billion and you now have PTSD specialists or treatment teams in every VA medical center, including an increasing number of programs for women veterans.

I'm very pleased with this priority. As you know, Senator Murray and I have just introduced a bill that would focus more on the unique women's needs in our veterans health care and you again, Secretary Peake, have already said that that will be a priority for you as well.

And I think that the other area, of course, is the traumatic brain injury treatment research—that we are committed to, that the Veterans Administration is also doing a great job of promoting as well as the gulf war syndrome research, which is still a lingering need—and the treatment for the loss of limbs and the rehab that is associated with that.

PREPARED STATEMENTS

So, we have a lot of priorities but I can't think of anything more important than doing it right and I know that the team that you are putting together is going to do that.

So, I want to thank you. As the former chairman and present ranking member, I know that the Veterans Administration has grown a lot in the health care field and we will work with you to continue that growth.

Thank you, Mr. Chairman.

[The statements follow:]

PREPARED STATEMENT OF SENATOR KAY BAILEY HUTCHISON

Thank you, Mr. Chairman. I am pleased to welcome Secretary Peake and our other witnesses and guests. Today, we will examine the President's budget request for the Department of Veterans Affairs, including funds for veterans' benefits, health care, and our national cemeteries.

Mr. Secretary, this subcommittee has always put our Nation's veterans first, and I can say with great assurance that we will do whatever it takes, in a bipartisan manner, to work with you to continue these efforts. From my experience as the recent Chair of this subcommittee and now as the ranking member, I respect the dedication and hard work of every member on this subcommittee and can assure you and our veterans of our support and cooperation.

There has certainly been a lot of public discussion lately about the ability of the Department of Veterans Affairs to deliver on its promises to America's veterans. This budget requests $91 billion to provide health care and benefits to the men and women whom we have asked to secure and protect our Nation. This is $46 billion in mandatory benefits and $45 billion for discretionary spending, which includes $39 billion for medical programs.

The Medical Services and Administration account request is $34.1 billion, a 4.5 percent increase over the fiscal year 2008 appropriated level, and the Medical Facilities request is $4.7 billion, a 14 percent increase over the fiscal year 2008 level. I know this growth is necessary to keep pace with the increasing costs of medical care and the heightened strain on our medical facilities.

As our brave men and women return from war, we want to be certain they receive the very best medical care our Nation can provide. I am pleased to see that your budget request keeps us on that track. I know it is difficult to anticipate every need, but this subcommittee will certainly make every effort to not only provide you the resources you need, but also to work with you so you can make adjustments as necessary to carry out your mission.

As more of our soldiers return home with delayed Post Traumatic Stress Disorder (PTSD), I am pleased to see the emphasis your budget places on mental health and rehabilitation. The VA's mental health program has grown to nearly $4 billion, and the department now has PTSD specialists or treatment teams in every VA Medical Center, including an increasing number of programs for women veterans. This subcommittee will continue to work with you to respond to the mental health needs of our returning veterans.

I am very appreciative of your recent visit to the Waco Center of Excellence in Mental Health. I am confident this facility is fast becoming a model for how consolidating personnel, training, collaboration and specialized resources produces world

class care in psychiatric rehabilitation and treatment. Their work includes close collaboration with the research facilities at Baylor University, Texas A&M University Medical School, Fort Hood Army Hospital, and the Mental Health Association from the State of Texas. It is one of the many great success stories of the VA.

I would also like to commend the VA for its research efforts. The VA has become the world's leader in traumatic brain injury treatment and research, and I am pleased with the collaborative efforts that have been put into investigating gulf war illness. I ask for your assurance that research into Gulf War illness will continue until we find a cure. We do not understand all of the factors that have caused serious health problems for our veterans who fought in the gulf region, but we are seeing the many effects. I am committed, as you are, to understanding and treating the service-connected illnesses of our gulf war veterans.

As more of our soldiers return home with multiple traumatic injuries, they must receive the very best health care our Nation can provide. The VA manages the only nationwide network to care for polytrauma patients and has become the world's leader in traumatic brain injury rehabilitation. I am extremely pleased with the VA's decision to build its fifth Level I polytrauma center in San Antonio. The San Antonio facility will assist veterans in rehabilitation, transitional living, and prosthetics, and based on the VA's experiences at the other four facilities, I am confident we can leverage that knowledge to make this new facility the VA's flagship for our Nation's most seriously wounded veterans.

New major construction projects like the one in San Antonio are vital to expand the VA's health infrastructure and handle its heightened workload. This has been an issue discussed many times on this subcommittee, but I note this year's major construction request is roughly half of last year's appropriation, despite the fact that there is more than $2.2 billion in ongoing projects that are not fully funded. I hope you will speak to this in your remarks, as I would like to hear more on the long-term capital plan of the VA.

I would also like to thank you again for your visit to Harlingen, Texas and the South Texas Valley and for your support of the health care needs of the veterans there. I believe the current plan for health care in this area could be a great model for VA health care in other parts of the Nation. I am most interested in your thoughts and vision on this particular model of health care for the future, and I hope you will address it in your remarks.

Mr. Secretary, I would also like to raise some concerns regarding the quality of veteran healthcare in El Paso, Texas. As you are aware, an internal Department of Veterans Affairs study on performance standards and healthcare delivery ranked the El Paso outpatient clinic well below the national average, and I find this most disturbing. I am committed to making sure that all of our veterans in Texas, and elsewhere in this country, receive the very best medical care this Nation can provide. I am very concerned about the veterans in El Paso experiencing unusually long waiting times for appointments, particularly specialty appointments, and having limited access to healthcare. I would like to know what the Department is doing to improve this situation and how I can be helpful to ensure that the veterans in the El Paso area receive the highest quality of healthcare.

On the subject of Electronic Health Records, it is the goal of everyone here today to have veterans seamlessly transition from the DOD to the VA. As I have done many times, I would like to commend the VA for taking the first step in that process by setting the "gold standard" for its use of electronic health care records. I hope you are able to convince the Department of Defense to build on your proven successes and not slow this effort down. Our veterans and our Nation's health care professionals need this innovative technology as soon as possible. The VA and DOD must be able to transfer medical information electronically and in both directions. I witnessed the value of this project first hand after the devastating hurricanes that damaged so much of our gulf coast in 2005, and I am very proud to say that no veteran went untreated, a fabulous achievement for the VA and the electronic health records program. As this program continues to be developed, I hope you can tell me when it will be completed and what the total cost will be.

Mr. Secretary, not only would a complete and interoperable electronic health care record system advance health care, it would speed up claims processing times, and we are very aware of the large backlog of claims. We are concerned that the average number of days to process benefits claims rose to 183 days in 2007 instead of dropping to 160 days, as initially estimated. We don't want our veterans waiting any longer than absolutely necessary to have their claims processed. We recognize that you have aggressively hired claims examiners over the past 2 years, but we are concerned that the IT management practices designed to help process claims are not what you or we would want them to be. This has become one of the major issues before this subcommittee. As we learned from the Dole-Shalala Commission it is

worth looking at the entire claims processing methodology to see if a new business process reengineering study is warranted. I welcome your comments on this issue as well.

Mr. Secretary, thank you for taking on this most challenging and critically important position of Secretary of the Department of Veterans Affairs and I am very confident that your accomplishments as a doctor and as a Surgeon General and your vision for health care in America make you the right person to lead our Nation's veterans today.

PREPARED STATEMENT OF SENATOR PATTY MURRAY

Chairman Johnson and Senator Hutchison, thank you for holding today's hearing to examine the President's proposed VA Budget for fiscal year 2009.

Senator Johnson, if I'm not mistaken, this is your first committee hearing as Chairman. Given your history of fighting for veterans, I know that you will do a fantastic job leading the committee.

Secretary Peake, it is good to see you again. Nearly 2 months ago, you testified in front of the Senate Veterans' Affairs Committee, of which I am a member, on the President's proposed fiscal year 2009 VA budget.

I told you then that many veterans—and many members of this committee—have placed a tremendous amount of faith in your ability to rise to the unprecedented challenges facing the VA today.

At that time, you had only been on the job for a month and a half. You have now been on the job for nearly 4 months. In the short time that you have served as VA Secretary, I am sure that you have gained a better perspective on the many challenges confronting the VA system.

That includes issues like:

—the increasing number of Iraq and Afghanistan veterans suffering from TBI and PTSD,

—the massive claims backlog,

—VA infrastructure upgrade needs,

—the growing number of women veterans using the system,

—and the unique challenges facing rural veterans, which you saw firsthand when you visited Walla Walla—in my home State of Washington—in February.

I believe that while that list is long, we can make progress.

However, I was very troubled to read the Associated Press report on Sunday, which found that VA employees had racked up hundreds of thousands of dollars on government credit cards at casinos, hotels and high-end retailers.

That report raises serious questions about spending oversight at the VA.

So I look forward to hearing your assessment of what happened—and I hope that steps have already been taken to ensure that waste and abuse can't happen in the future.

Mr. Secretary, you also know from our hearing in February that I have a number of problems with the President's proposed VA budget.

First and foremost, I am concerned that it closes the VA's door to thousands of our Nation's veterans by proposing new fees and increased co-pays that will discourage veterans from accessing the VA.

While the exact cost of these new taxes on veterans is not included in this year's budget, in previous budgets, the administration has estimated that these fees and co-pays would result in:

—nearly 200,000 veterans leaving the system,

—and more than 1 million veterans choosing not to enroll.

I'm also extremely disappointed that this budget continues to bar Priority 8 veterans from enrolling in the VA healthcare system.

I understand that you are conducting an in-depth review of this policy and I will have some questions for you about this issue later.

Second, I am concerned that this budget won't meet the real needs of veterans once medical inflation and other factors are considered.

The Independent Budget estimates that the true cost of VA medical care is actually $1.6 billion more than the President's request.

Along the same line, I'm also troubled that the President is proposing an 8 percent cut for VA medical and prosthetic research.

As we all know, one of the signature injuries of the war in Iraq is traumatic brain injury. But there is still a great deal we don't know about the condition.

Cutting funding for research seems like the wrong thing to do as we attempt to better understand the injuries our veterans are experiencing.

Third, I am incredibly concerned that the President's budget proposes cutting funding for major and minor construction by nearly 50 percent—at a time when the list of needed repairs and expanded facilities is stacking up.

The administration's own budget documents detail the numerous projects that won't receive funding this year, including projects in Seattle, American Lake and Walla Walla.

I continue to be absolutely shocked that at a time when thousands of new veterans are entering the VA system with serious medical needs as a result of the wars in Iraq and Afghanistan, the administration is underestimating the cost of medical care, and it is cutting funding for construction and medical and prosthetic research.

And at a time when older veterans are seeking care in record numbers, I am stunned that the President is proposing fees and co-pays that will shut the door to thousands of patients.

We know all too well what happens when the VA gets shortchanged. The men and women who have served us end up paying the biggest price.

Our veterans are our heroes, and they deserve the best we can give them. I believe we can do a lot better than this budget.

So, Secretary Peake, I have a number of questions for you, and I'm looking forward to your answers.

STATEMENT OF SENATOR LARRY CRAIG

Senator JOHNSON. Senator Craig.

Senator CRAIG. Mr. Chairman, thank you, and it's great to see you back chairing the committee.

Mr. Chairman and Ranking Member Hutchison, let me thank you for the hearing today, and Secretary Peake, it's good to see you again and thank you for being with us. It's also good to see Under Secretary Tuerk. Thank you for being here.

As many of you know, he served with me as chief counsel on the Veterans Affairs Committee when I chaired that a few years ago and did an exemplary job there and under his current service, I am sure that is the same.

I'm proud to be in the unique position to serve as an appropriator and an authorizer for veterans issues. I think all of us realize the challenges that our veterans are facing. It is difficult but it is also fluid. Modern day veterans are facing issues that a generation ago were either not recognized or simply not understood.

During a time of war, it is essential that the Government not turn a blind eye on the needs of veterans, and I think this Congress has provided unprecedented increases for our veterans to try to meet these demands. We should be proud as a Congress of the work we are doing and the work we've done.

But over the past few years, I've been making the case that a better VA doesn't simply mean a more expensive VA. I mentioned the unprecedented increases over the past 5 years, Mr. Chairman, 11 percent, 13 percent, 15 percent. Last year, I believe we topped a near 18 percent in increases for VA and there's a practical question to be asked.

Is that sustainable? Is that a figure that this Congress and with all of our budget constraints can sustain? I fully expect the President's budget request of $93.7 billion to reach upwards of a $100 billion before Congress gets through with it and through with the VA MILCON bill, Mr. Chairman.

This is an enormous figure and it begs the question as to whether the VA can effectively and efficiently spend that kind of money. Simple systems of bricks and mortar? Well, I have suggested that we adapt to current realities. In fact, I must say, Mr. Chairman, there were a group of veterans in my office yesterday from all parts

of Idaho, young men and women who had just served in Iraq and Vietnam, and one of them held up a credit card and said why can't I have a VA health card that allows me to enter any health care facility in my State and gain my benefits through this system instead of having to go to a specific location 400 miles from where I live to a specific hospital?

In other words, he was a contemporary man, a contemporary veteran talking about a contemporary idea, and while I know that is an anathema in the system of bricks and mortars and bureaucracies today, I suggested to him that he as a young veteran start a drumbeat with veterans service organizations and by the time he was as old as I am, he might realize the opportunity to change the system, to modernize it, and to make it so fluid and accessible to veterans in a way that, frankly, I think we have to go to in the future.

Having said that, that doesn't happen tomorrow and it certainly isn't going to happen in this budget, but flexibility in the system is growing and it should grow. We're going to open a new community outpatient—a CBOC, I got it right, in Lewiston, and that CBOC is going to contract with the local hospital for some of the services they cannot provide and we feel must be provided for the veterans. So already that type of thing has started.

Last, Mr. Chairman, I would like to mention a project that was started in my home State of Idaho by a former director of the Idaho Veterans Cemetery. It's called the Missing in America Project and I think it serves a very worthy case.

Mr. Chairman, I'd like to introduce into the record a letter I received from that former director of the Idaho Veterans Cemetery regarding this special program and the letter contains the information and five specific points I'd like the VA to answer and get back to me on.

LETTER FROM RICHARD CESLER

Honorable Senator Larry Craig,
U.S. Senator Washington, DC.

DEAR SENATOR: I appreciate your efforts concerning the "Missing In America Project" begun in Idaho in 2006 and resulting that year in the recovery of 21 veterans and one spouse from Funeral Homes. On November 9, 2007, 13 additional veterans and three spouses were given honor and placed in the Idaho State Veterans Cemetery.

Those abandoned veterans deserved that honorable placement in our State Veterans Cemetery.

First, however, let me thank you personally for your actions to remove the 2 year limitation for plot allowance claim from the Federal Code by the enacting of Public Law 110–157, December 26, 2007. This is one step towards addressing the issues of recovering our veteran heroes.

My estimation is that there are at least 1,000 or more still left for discovery in Idaho alone. There is no law established at this time to extract the information from those Funeral Homes that refuse to corporate or ignore repeated request to at least provide a list of their shelved cremains. This must happen to begin the process of identification.

I would like to pose several questions for the Veterans Affairs Secretary Dr. Peake and his staff Directors and Under Secretaries:

—Are you aware of the issue of abandoned veterans in Funeral Homes, coroner offices and other facilities around our nation.

—What steps has the VA taken to address the issue.

—Can the VA initiate authority to set up a new division/office to address this matter.

—Is the VA aware that several States have taken action through their legal process to help in this recovery. Please be aware that this is a slow and painful way to resolve what must truly be a Veterans Affairs matter.
—Will the VA take the steps necessary to begin discussion of this issue.
Thank you for allowing me to honor your achievements with regards to veterans during your tenure as my State Senator.
Best regards,

RICHARD CESLER.

Senator CRAIG. Essentially, this program works to find unclaimed veterans remains in coordination with funeral homes across the State, to identify and reinter veterans in State VA cemeteries. This seems like the kind of effort the VA should be taking a lead on and I hope that you will respond to this challenge.

Related to this subject, I am pleased that the language I worked out last year to assist States with the interment of unclaimed veterans was signed into law at the close of 2007. This law allows the VA to reimburse States, such as Idaho, which identify unclaimed remains and reinter them in the State VA cemeteries.

I'm very pleased that I was able to work on this legislation, not only to help Idaho but now to help the Nation with this kind of an opportunity.

So once again, gentlemen of the VA, thank you for being with us and, Mr. Chairman, thank you, look forward to working with you as we bring about the critical and necessary budget for our veterans.

Senator JOHNSON. There is a vote called, Floor votes.

Senator CRAIG. Just now?

Senator JOHNSON. Just now. Senator Allard, would you like to make a brief statement?

Senator ALLARD. Yes, I would like to, if I might, then be ready to line up with everybody else for the questioning period.

You're going to continue with questions after our votes, I assume?

Senator JOHNSON. Yes.

Senator ALLARD. Okay. Very good.

STATEMENT OF SENATOR WAYNE ALLARD

Senator ALLARD. Thank you, Mr. Chairman, for holding this important hearing today, and I appreciate all our witnesses appearing before the committee this afternoon.

You know, it's a very difficult time in our Nation's history. We have currently in the United States more than 23 million living veterans, 800,000 of which are veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom operations.

As this war continues, the United States will be faced with an increasing need for veteran services. Our men and women returning from war deserve our utmost care and attention as does all our veterans who have so admirably served in the past.

We're dealing with a different kind of injury than what we had in conflicts in the past that we will have to continue to deal with throughout the life of the soldiers.

While it's vitally important to provide our veterans with the best service possible, it's also important that we watch our Federal spending and look to reduce our Federal debt wherever possible in the coming years.

That being said, it's important that we continue to prioritize programs and ensure efficient spending. I hope that we're able to answer the needs for all these men and women who have been called to serve their country and have done so courageously.

Mr. Secretary, I look forward to discussing these issues further this afternoon, and I'd like to again reiterate my thanks for appearing in front of us today and looking forward to your testimony.

Thank you, Mr. Chairman.

Senator JOHNSON. Yes.

Senator HUTCHISON. Mr. Chairman, were you going to recess the meeting until after all of the votes?

Senator JOHNSON. After all the votes.

Senator HUTCHISON. The five?

Senator JOHNSON. After the five votes. Mr. Secretary, I apologize, but we need to put this hearing into a short recess.

Senator HUTCHISON. Five votes, an hour and a half or so.

Senator JOHNSON. Yes.

Senator HUTCHISON. Sorry.

Senator JOHNSON. This hearing will come to order. I apologize for the delay.

STATEMENT OF JAMES B. PEAKE

Secretary PEAKE. With your permission, Mr. Chairman, I have a written statement that I would like to submit for the record.

Senator JOHNSON. That will be fine.

Secretary PEAKE. Mr. Chairman, ladies and gentlemen of the committee, I am honored to be here as the sixth Secretary of Veterans Affairs and now responsible for the care of our veterans. I appreciate the opportunity that the President has given to be able to make a difference.

With me today to present the President's 2009 budget proposal for VA is the leadership of our Department. On my far left are General Counsel Paul Hutter, Admiral Pat Dunne, our Acting Assistant Secretary for Benefits, Dr. Mike Kussman, Brigadier General Mike Kussman, our Under Secretary for Health. On my far right, Bob Howard, our Assistant Secretary for Information Technology, our Under Secretary for Memorial Affairs Bill Tuerk, and Mr. Bob Henke, Assistant Secretary for Management.

In my now nearly 3½ months at the VA, I have seen both the compassion and the professionalism of our employees. It is, frankly, just what I expected. The culture is one of deep respect for the men and women that we serve.

This group at the table and the VA at large understands that America is at war and it is not business as usual. I appreciate the importance of and I look forward to working with this committee to build on VA's past successes but also to look to the future to ensure veterans continue to receive timely, accessible delivery of high-quality benefits and services earned through their sacrifice and service and that we meet the needs of each segment of our veterans population.

The President's request totals nearly $93.7 billion, $46.4 billion for entitlement programs and $47.2 billion for discretionary programs. The total request is $3.4 billion above the funding level for

2008 and that funding level is the one that includes a $3.7 billion plus-up from the emergency funding.

This budget will allow the VA to address the areas critical to our mission; i.e., providing timely, accessible, high-quality health care to our highest-priority patients. We will advance our collaborative efforts with the Department of Defense to ensure the continued provision of worldclass health care and benefits to VA and DOD beneficiaries, including the progress toward development of secure interoperable electronic medical records systems.

We will improve the timeliness and accuracy of our claims processing and ensure the burial needs of veterans and their eligible family members are met and maintain veteran cemeteries as national shrines.

The young men and women in uniform who are returning from Iraq and Afghanistan and their families represent a new generation of veterans. Their transition and reintegration into our civilian society when they take off that uniform is a prime focus. Those seriously injured must be able to transition between the DOD and VA systems as they move on their journey of recovery.

This budget funds our polytrauma centers and sustains the network of polytrauma care that Dr. Kussman and his team have put in place. It funds the Federal recovery coordinators envisioned by the report of the Dole-Shalala Commission and sustains the ongoing case management at all levels of our system.

We know that our prostheses must keep pace with the newest generation of prostheses as our wounded warriors transition into the VA system and you will see a 10 percent increase in our budget for this.

In 2009, we expect about 333,000 OEF/OIF veterans, a 14 percent increase. With the potential of rising costs per patient, we have budgeted a 21 percent increase in our costs. That is nearly $1.3 billion to meet the needs of the OEF/OIF veterans that we expect will come to the VA for medical care.

This budget will sustain our outreach activities that range from more than 799,000 letters to the greater than 205,000 engagements that our vet center outreach personnel have made with returning National Guard and Reserve units as part of the Post Deployment Health Reassessment process. VBA alone conducted about 8,000 military briefings to nearly 300,000 service men and women. This is also part of seamless transition.

Now with the authority to provide care for 5 years of service-related issues, we can without bureaucracy offer the counseling, support and care that might be needed to avert or mitigate future problems. I highlight the outreach because we want these men and women to get those services.

Mental health, from PTSD to depression to substance abuse, are issues that I know are of concern to you and of great concern to us. This budget proposes $3.9 billion for mental health across the board, a 9 percent increase from 2008. It will allow us to sustain an access standard that says if you show up for mental health, you will be screened in 24 hours and within 14 days have a full mental health evaluation, if needed. It will keep expanding mental health access according to a uniform mental health package. Trained mental health professionals in each CBOC, and there are 51 new

CBOCs, by the way, planned for 2009, in addition to the 64 that are coming from 2008.

Our vet centers will bring on yet an additional hundred OIF/OEF counselors and Dr. Kussman is prepared, as needed, to identify and add additional vet centers.

We appreciate the issues of rural access in this arena and our vet centers are budgeted for 50 new vans to support remote access and this budget supports their operation as well as expanding telemental health to 25 locations.

But this budget and our mission is more than just about these most recently returning service men and women. We should remember that 20 percent of VA patients, who in general are older and with more comorbid conditions than the general population have a mental health diagnosis.

In fiscal year 2007, we saw 400,000 veterans of all eras with PTSD. This budget will sustain VA's internationally recognized network of more than 200 specialized programs for the treatment of posttraumatic stress disorder through our medical centers and clinics that serve all of our veterans.

We have a unique responsibility to serve those who have served before. We still have one World War I veteran in our fold. World War II and Korea veterans are recipients of our geriatric care and our efforts are aimed at improving long-term, not institutional, care where in this budget we have increased funding by 28 percent will make a huge difference in their quality of life.

We have currently 32,000 people served by home telehealth programs. This budget continues our work in this area and in the expansion of home-based primary care. Overall, the President's 2009 budget includes a total of $41.2 billion for VA medical care, an increase of $2.3 billion over the 2008 level and more than twice the funding available at the beginning of the administration.

With it, we will provide quality care, improve access, and expand special services to the 5,771,000 patients we expect to treat in 2009. That is 1.6 percent above our current 2008 estimate.

In April 2006, there were over 250,000 unique patients waiting more than 30 days for their desired appointment date. That's too many. As of January 1, 2008, we had reduced the waiting list to just over 69,000. At the end of March, it was down to 45,000. Our budget request for 2009 provides the resources to virtually eliminate the waiting list by the end of next year.

Information technology crosscuts the entire Department and this budget provides more than $2.4 billion for this vital function, 19 percent above our 2008 budget, and reflects the realignment of all IT operations and functions under the management control of our chief information officer.

A majority, $261 million, of that increase in IT funds will support VA's Medical Care Program, particularly VA's electronic health record system. I emphasize it here because it is so central to the care that we provide, touted in such publications as the book "Best Care Anywhere" as the key to our quality that is lauded worldwide.

This IT budget also includes all the infrastructure support, such as hardware, software, communications systems for those 51 CBOCs that I mentioned, and there is $93 million for cyber security, continuing us on the road to being the gold standard.

IT will also be key as we begin to move our claims model down the road to a paperless process. It is an investment we must make. This budget sustains the work in VetsNet that is giving us management data to really get after our claims processing and Virtual VA, our electronic data repository.

In addition to IT, this budget sustains a 2-year effort to hire and train 3,100 new staff to achieve our 145-day goal for processing comp and pension claims in 2009. This is a 38-day improvement in processing timeliness from 2007 and a 24-day or 14 percent reduction from this year.

This is important because the volume of claims receipts is projected to reach 872,000 in 2009, a 51 percent increase since 2000. The active, Reserve and National Guard returning from OIF and OEF have contributed to an increase in new claims and bring with them an increased number of issues with each claim.

If you look at the graph there, you see the claims going up in the bottom line. The issues, the number of individual pieces of that claim, number of individual issues growing significantly at a faster rate, and what our VBA has been able to do, even with that, as you see in the middle, the average number of days to complete has remained relatively stable and we intend to bring that down with these new people.

The President's 2009 budget includes seven legislative proposals totaling $42 million. One of these proposals expands legislative authority to cover payments for specialized residential care and rehab in VA-approved medical foster homes for OIF and OEF veterans with TBIs, as an example.

We again bring to you a request for enrollment fees for those who can afford to pay and for a raise in the co-pays. Again this does not affect our VA budget as the funds would return to the Treasury, that's $5.2 billion over 10 years, but it does reflect the matter of equity for those veterans who have spent a full career in the service and under TRICARE do pay an annual enrollment fee for life care.

The 442 million to support VA's Medical and Prosthetic Research Program, though less than what we have from the augmented 2008 budget, is actually 7.3 percent more than what we received in 2006 and about 7.5 percent more than what we actually asked for in 2007 and 2008.

It does contain $252 million devoted to research projects focused specifically on veterans returning from service in Afghanistan and Iraq, including projects on TBI and polytrauma and spinal code injury and prosthetics and burn injury and pain and postdeployment mental health. In fact, we anticipate with Federal and other grants a full research portfolio of about $1.85 billion.

This budget request includes just over a billion in capital funding for VA, with resources to continue five medical facility projects already underway in Denver, in Orlando, in Lee County, Florida, San Juan and St. Louis, and to begin three new medical facility projects at Bay Pines, Tampa, Palo Alto, two of which relate to the polytrauma rehabilitation centers and continue our priority for this specialized area of excellence.

And finally, we will perform 111,000 interments in 2009, 11 percent more than in 2007. The $181 million in this budget for the Na-

tional Cemetery Administration is 71 percent above the resources available to the Department's Burial Program when the President took office.

These resources will operationalize the six new national cemeteries that will open this year, providing a VA burial option to nearly 1 million previously unserved veteran families and will maintain our cemeteries as national shrines that will again earn the highest marks in the government or private sector for customer satisfaction.

PREPARED STATEMENT

This budget of nearly $93.7 billion, nearly double from 7 years ago, and with a health care component more than twice what it was 7 years ago, will allow us to make great progress in the care of all of our veterans and will keep us on this quality journey in health and the management of an extraordinary benefit and in ensuring the excellence of our final tribute to those who shall have borne the battle.

It's an honor to be with you today and I look forward to your questions.

[The statement follows:]

PREPARED STATEMENT OF JAMES B. PEAKE

Mr. Chairman and members of the committee, good afternoon. I am happy to be here and I am deeply honored that the President has given me the opportunity to serve as Secretary of Veterans Affairs. I look forward to working with you to build on VA's past successes to ensure veterans continue to receive timely, accessible delivery of high-quality benefits and services earned through their sacrifice and service in defense of freedom.

I am here today to present the President's 2009 budget proposal for VA. The request totals nearly $93.7 billion—$46.4 billion for entitlement programs and $47.2 billion for discretionary programs. The total request is $3.4 billion above the funding level for 2008. The President's ongoing commitment to those who have faithfully served this country in uniform is clearly demonstrated through this budget request for VA. Resources requested for discretionary programs in 2009 are more than double the funding level in effect when the President took office 7 years ago.

The President's request for 2009 will allow VA to achieve performance goals in four areas critical to the achievement of our mission:

—provide timely, accessible, and high-quality health care to our highest priority patients—veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs;
—advance our collaborative efforts with the Department of Defense (DOD) to ensure the continued provision of world-class health care and benefits to VA and DOD beneficiaries, including progress towards the development of secure, interoperable electronic medical record systems;
—improve the timeliness and accuracy of claims processing; and
—ensure the burial needs of veterans and their eligible family members are met and maintain veterans' cemeteries as national shrines.

ENSURING A SEAMLESS TRANSITION FROM ACTIVE MILITARY SERVICE TO CIVILIAN LIFE

One of our highest priorities is to ensure that veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom receive everything they need to make their transition back to civilian life as smooth and easy as possible. We will take all measures necessary to provide them with timely benefits and services, to give them complete information about the benefits they have earned through their courageous service, and to implement streamlined processes free of bureaucratic red tape.

We will provide timely, accessible, and high-quality medical care for those who bear the permanent physical scars of war as well as compassionate care for veterans who suffer from less visible but equally serious and debilitating mental health

issues, including traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). Our treatment of those with mental health conditions will include veterans' family members who play a critical role in the care and recovery of their loved ones. To help meet the increased need for mental health services, especially those returning from the Global War on Terror, VA is expanding its training program for psychologists. The best resource for VA recruitment of psychologists has been the Department's own training program. Nearly three-quarters of the psychologists hired in the last 2 years have had VA training.

The President's top legislative priority for VA is to implement the recommendations of the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission). The Commission's report provides a powerful blueprint to move forward with ensuring that service men and women injured during the Global War on Terror continue to receive the health care services and benefits necessary to allow them to return to full and productive lives as quickly as possible. VA has initiated studies to determine appropriate payment levels for quality of life, transition assistance, and loss of earnings. The next step is for Congress to pass the President's legislation, which will modernize the disability compensation system. VA is working closely with officials from DOD on the recommendations of the Dole-Shalala Commission that do not require legislation to help ensure veterans achieve a smooth transition from active military service to civilian life.

For example, VA and DOD signed an agreement in October 2007 to provide Federal recovery coordinators to ensure medical services and other benefits are provided to seriously-wounded, injured, and ill active duty service members and veterans. VA hired the first recovery coordinators, in coordination with DOD, and they are located at Walter Reed Army Medical Center, National Naval Medical Center, and Brooke Army Medical Center. They will coordinate services between VA and DOD and, if necessary, private-sector facilities, while serving as the ultimate resource for families with questions or concerns about VA, DOD, or other Federal benefits.

In November 2007, VA and DOD began a pilot disability evaluation system for wounded warriors at the major medical facilities in the Washington, DC area—Washington VA Medical Center, Walter Reed Army Medical Center, National Naval Medical Center, and Malcolm Grow Medical Center. This initiative is designed to eliminate the duplicative and often confusing elements of the current disability processes of the two departments. Key features of the disability evaluation system pilot include one medical examination and a single disability rating determined by VA. The single disability examination is another improvement resulting from the recommendations of the Dole-Shalala Commission and is aimed at simplifying benefits, health care, and rehabilitation for injured service members and veterans.

VA will continue to work with Congress, DOD, and other Federal agencies to aggressively move forward with implementing the Dole-Shalala Commission recommendations.

MEDICAL CARE

The President's 2009 request includes total budgetary resources of $41.2 billion for VA medical care, an increase of $2.3 billion over the 2008 level and more than twice the funding available at the beginning of the Bush administration. Our total medical care request is comprised of funding for medical services ($34.08 billion), medical facilities ($4.66 billion), and resources from medical care collections ($2.47 billion). We have included funds for medical administration as part of our request for medical services. Merging these two accounts will improve and simplify the execution of our budget and will make it easier for us to respond rapidly to unanticipated changes in the health care environment throughout the year. We appreciate Congress providing us with the authority to transfer funding between our medical care accounts. We will need to exercise this authority in 2008 to help ensure we operate a balanced medical program.

Information technology (IT) plays a vital role in direct support of our medical care program and VA is requesting a significant increase in IT funding in 2009, much of which will help ensure we continue to provide timely, safe, and high-quality health care services. The most critical component of our medical IT program is the continued operation and improvement of our electronic health record system, a Presidential priority which has been recognized nationally for increasing productivity, quality, and patient safety. We must continue the progress we have made with DOD to develop secure, interoperable electronic medical record systems which is a critical recommendation in the Dole-Shalala Commission report. The availability of medical data to support the care of patients shared by VA and DOD will enhance our ability to provide world-class care to veterans and active duty members, including our wounded warriors returning from Afghanistan and Iraq.

Workload

During 2009, we expect to treat about 5,771,000 patients. This total is nearly 90,000 (or 1.6 percent) above the 2008 estimate. Our highest priority patients (those in priorities 1–6) will comprise 67 percent of the total patient population in 2009, but they will account for 84 percent of our health care costs.

We expect to treat about 333,000 veterans in 2009 who served in Operation Enduring Freedom and Operation Iraqi Freedom. This is an increase of 40,000 (or 14 percent) above the number of veterans from these two campaigns that we anticipate will come to VA for health care in 2008, and 128,000 (or 62 percent) more than the total in 2007.

Funding for Major Health Care Initiatives

In 2009 we are requesting nearly $1.3 billion to meet the needs of the 333,000 veterans with service in Operation Enduring Freedom and Operation Iraqi Freedom whom we expect will come to VA for medical care. This is an increase of $216 million (or 21 percent) over our resource needs to care for these veterans in 2008.

The Department's resource request includes $3.9 billion in 2009 to continue our effort to improve access to mental health services across the country. This is an increase of $319 million, or 9 percent, above the 2008 level. These funds will help ensure VA continues to realize the aspirations of the President's New Freedom Commission Report, as embodied in VA's Mental Health Strategic Plan, to deliver exceptional, accessible mental health care. The Department will place particular emphasis on providing care to those suffering from PTSD as a result of their service in Operation Enduring Freedom and Operation Iraqi Freedom. An example of our firm commitment to provide the best treatment available to help veterans recover from these mental health conditions is our increased outreach to veterans of the Global War on Terror, as well as increased readjustment and PTSD services. Our strategy for improving access includes increasing mental health care staff and expanding our telemental health program that allows us to reach about 20,000 additional patients with mental health conditions each year.

Our 2009 request includes $762 million for non-institutional long-term care services, an increase of $165 million, or 28 percent, over 2008. By enhancing veterans' access to non-institutional long-term care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes surrounded by their families. This includes adult day health care, home-based primary care, purchased skilled home health care, homemaker/home health aide services, home respite and hospice care, and community residential care. During 2009 we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 61,000. This represents a 38 percent increase above the level we expect to reach in 2008.

VA's medical care request includes nearly $1.5 billion to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. This is $134 million, or 10 percent, above the funding level in 2008. This increase in resources for prosthetics and sensory aids will allow the Department to meet the needs of the growing number of injured veterans returning from combat in Afghanistan and Iraq.

Requested funding for the Civilian Health and Medical Program of the VA (CHAMPVA) totals just over $1 billion in 2009, an increase of $145 million (or 17 percent) over the 2008 resource level. Claims paid for CHAMPVA benefits are expected to grow by 9 percent (from 7.0 million to 7.6 million) between 2008 and 2009 and the cost of transaction fees required to process electronic claims is rising as well.

Our budget request contains $83 million for facility activations. This is $13 million, or 19 percent, above the resource level for activations in 2008. As VA completes projects within our Capital Asset Realignment for Enhanced Services (CARES) program, we will need increased funding to purchase equipment and supplies for newly constructed and leased buildings.

Quality of Care

The resources we are requesting for VA's medical care program will allow us to strengthen our position as the Nation's leader in providing high-quality health care. VA has received numerous accolades from external organizations documenting the Department's leadership position in providing world-class health care to veterans. For example, our record of success in health care delivery is substantiated by the results of the December 2007 American Customer Satisfaction Index (ACSI) survey. Conducted by the National Quality Research Center at the University of Michigan Business School and the Federal Consulting Group, the ACSI survey found that cus-

tomer satisfaction with VA's health care system was higher than the private sector for the eighth consecutive year. The data revealed that patients at VA medical centers recorded a satisfaction level of 83 out of a possible 100 points, or 6 points higher than the rating for care provided by the private-sector health care industry.

In December 2007 the Congressional Budget Office (CBO) issued a report highlighting the success of VA's health care system. In this report—The Health Care System for Veterans: An Interim Report—the CBO identified organizational restructuring and management systems, the use of performance measures to monitor key processes and health outcomes, and the application of health IT as three of the major driving forces leading to high-quality health care delivery in VA. In October 2007, the Institute of Medicine released a report—Treatment of PTSD: An Assessment of The Evidence—that states VA's use of exposure-based therapies for the treatment of PTSD is effective. This confirms the Department's own conclusions and bolsters our efforts to continue to effectively treat veterans of the Global War on Terror who are suffering from PTSD and other mental health conditions.

These external acknowledgments of the superior quality of VA health care reinforce the Department's own findings. We use two primary measures of health care quality—clinical practice guidelines index and prevention index. These measures focus on the degree to which VA follows nationally recognized guidelines and standards of care that the medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the clinical practice guidelines index, which focuses on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to grow to 86 percent in 2009, or a 1 percentage point rise over the level we expect to achieve in 2008. As an indicator aimed at primary prevention and early detection recommendations dealing with immunizations and screenings, the prevention index will also grow by 1 percentage point above the estimated 2008 level, reaching 89 percent in 2009.

To deal with a nationwide shortage of nurses and to improve the quality of care for veterans, VA has created a travel nurse corps to enable nurses to travel and work throughout the Department's health care system. Beginning as a 3-year pilot, the travel nurse corps is based at the Phoenix VA Health Care System and will place as many as 75 nurses at VA medical centers around the country. Participating nurses may be temporarily assigned to distant medical centers and clinics to help nursing staffs that have vacancies, reduce wait times, or maintain high-skill services and procedures.

Access to Care

In April 2006 there were over 250,000 unique patients waiting more than 30 days for their desired appointment date for health care services. As of March 1, 2008, we had reduced the waiting list to fewer than 49,000. Our budget request for 2009 provides the resources necessary for the Department to virtually eliminate the waiting list by the end of next year. Improvements in access to health care will result in part from the opening of new community-based outpatient clinics during the next 2 years, bringing the total number to 846 by the end of 2009.

The Department will expand its telehealth program which is a critical component of VA's approach to improve access to health care for veterans living in rural and remote areas. Other strategies include increasing the number of community-based outpatient clinics and enhancing VA's participation in the National Rural Development Partnership that serves as a forum for identifying, discussing, and acting on issues affecting those residing in rural areas. In 2009 the Department's Office of Rural Health will conduct studies to evaluate VA's rural health programs and develop policies and additional programs to improve the delivery of health care to veterans living in rural and remote areas. In addition, VA created a Rural Health National Advisory Committee in February 2008 to advise the Department's senior leaders about health care issues affecting veterans in rural areas. The committee members will come from the Federal, State, and local sectors, as well as from academia and veterans service organizations.

Medical Collections

The Department expects to receive nearly $2.5 billion from medical collections in 2009, which is $126 million, or more than 5 percent, above our projected collections for 2008. About $8 of every $10 in additional collections will come from increased third-party insurance payments, with almost all of the remaining collections resulting from growing pharmacy workload. We will continue several initiatives to strengthen our collections processes, including expanded use of both the Consolidated Patient Account Center to increase collections and improve operational performance, and the Insurance Card Buffer system to improve third-party insurance verification. In addition, we will enhance the use of real-time outpatient pharmacy

claims processing to facilitate faster receipt of pharmacy payments from insurers and will expand our campaign to increase the number of payers accepting electronic coordination of benefits claims.

Legislative Proposals

The President's 2009 budget includes seven legislative proposals totaling $42 million. One of these proposals expands legislative authority to cover payment of specialized residential care and rehabilitation in VA-approved medical foster homes for veterans of Operation Enduring Freedom and Operation Iraqi Freedom who suffer from TBI. Another proposal would reduce existing barriers to the early diagnosis of human immunodeficiency virus (HIV) infection by removing requirements for separate written informed consent for HIV testing among veterans. This change would ensure that patients treated by VA receive the same standard of HIV care that is recommended to non-VA patients.

The 2009 budget also contains three legislative proposals which ask veterans with comparatively greater means and no compensable service-connected disabilities to assume a modest share of the cost of their health care. They are exactly the same as proposals submitted but not enacted in the 2008 budget. The first proposal would assess Priority 7 and 8 veterans with an annual enrollment fee based on their family income:

Family Income	Annual Enrollement Fee
Under $50,000	([1])
$50,0000–74,999	$250
$75,000–99,999	500
$100,000 and above	750

[1] None.

The second legislative proposal would increase the pharmacy co-payment for Priority 7 and 8 veterans from $8 to $15 for a 30-day supply of drugs. And the last provision would equalize co-payment treatment for veterans regardless of whether or not they have insurance.

These legislative proposals have been identified in VA's budget request for several years. The proposals are consistent with the priority system of health care established by Congress, a system which recognizes that priority consideration must be given to veterans with service-disabled conditions, those with lower incomes, and veterans with special health care needs.

These proposals have no impact on the resources we are requesting for VA medical care as they do not reduce the discretionary medical care resources we are seeking. Our budget request includes the total funding needed for the Department to continue to provide veterans with timely, accessible, and high-quality medical services that set the national standard of excellence in the health care industry. Instead, these three provisions, if enacted, would generate an estimated $2.3 billion in revenue from 2009 through 2013 that would be deposited into a mandatory account in the Treasury.

One of our highest legislative priorities is to establish the position of Assistant Secretary for Acquisition, Logistics, and Construction. The person occupying this new position would serve as VA's Chief Acquisition Officer, a position required by the Services Acquisition Reform Act of 2003. This will elevate the importance of these critical functions to the level necessary to coordinate their policy direction across the Department's programs and other government agencies. An Assistant Secretary with focused policy responsibility for acquisition, logistics, and construction would ensure these vital activities receive the visibility they need at the highest levels of VA. Legislation to accomplish this was introduced in the Senate on October 4, 2007, as S. 2138. We would appreciate Congress' support of this legislation.

MEDICAL RESEARCH

VA is requesting $442 million to support VA's medical and prosthetic research program. Our request will fund nearly 2,000 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of mental illness ($53 million), aging ($45 million), health services delivery improvement ($39 million), cancer ($37 million), and heart disease ($33 million).

One of our highest priorities in 2009 will be to continue our aggressive research program aimed at improving the lives of veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom. The President's budget re-

quest for VA contains $252 million devoted to research projects focused specifically on veterans returning from service in Afghanistan and Iraq. This includes research in TBI and polytrauma, spinal cord injury, prosthetics, burn injury, pain, and post-deployment mental health. Our research agenda includes cooperative projects with DOD to enhance veterans' seamless transition from military treatment facilities to VA medical facilities, particularly in the treatment of veterans suffering from TBI.

The President's request for research funding will help VA sustain its long track record of success in conducting research projects that lead to clinically useful interventions that improve the health and quality of life for veterans as well as the general population. Recent examples of VA research results that have direct application to improved clinical care include the use of a neuromotor prosthesis to help replace or restore lost movement in paralyzed patients, continued development of an artificial retina for those who have lost vision due to retinal damage, use of an inexpensive generic drug (prazosin) to improve sleep and reduce trauma nightmares for veterans with PTSD, and advancements in identifying a new therapy to prevent or slow the progression of Alzheimer's disease.

In addition to VA appropriations, the Department's researchers compete for and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2009. Through a combination of VA resources and funds from outside sources, the total research budget in 2009 will be almost $1.85 billion.

GENERAL OPERATING EXPENSES

The Department's 2009 resource request for General Operating Expenses (GOE) is $1.7 billion. Within this total GOE funding request, nearly $1.4 billion is for the management of the following non-medical benefits administered by the Veterans Benefits Administration (VBA)—disability compensation; pensions; education; housing; vocational rehabilitation and employment; and insurance. The 2009 budget request provides VBA over two times the level of discretionary funding available when the President took office and underscores the priority this administration places on improving the timeliness and accuracy of claims processing. Our request for GOE funding also includes $328 million to support General Administration activities.

Compensation and Pensions Workload and Performance Management

A major challenge in improving the delivery of compensation and pension benefits is the steady and sizeable increase in workload. The volume of claims receipts is projected to reach 872,000 in 2009—a 51 percent increase since 2000.

The number of active duty service members as well as reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom is one of the key drivers of new claims activity. This has contributed to an increase in the number of new claims, and we expect this pattern to persist at least for the near term. An additional reason that the number of compensation and pension claims is climbing is the Department's commitment to increase outreach. We have an obligation to extend our reach as far as possible and to spread the word to veterans about the benefits and services VA stands ready to provide.

Disability compensation claims from veterans who have previously filed a claim comprise about 54 percent of the disability claims received by the Department each year. Many veterans now receiving compensation suffer from chronic and progressive conditions, such as diabetes, mental illness, cardiovascular disease, orthopedic problems, and hearing loss. As these veterans age and their conditions worsen, VA experiences additional claims for increased benefits.

The growing complexity of the claims being filed also contributes to our workload challenges. For example, the number of original compensation cases with eight or more disabilities claimed increased by 168 percent during the last 7 years, reaching over 58,500 claims in 2007. Over one-quarter of all original compensation claims received last year contained eight or more disability issues. In addition, we expect to continue to receive a growing number of complex disability claims resulting from PTSD, TBI, environmental and infectious risks, complex combat-related injuries, and complications resulting from diabetes. Claims now take more time and more resources to adjudicate. Additionally, as VA receives and adjudicates more claims, this results in a larger number of appeals from veterans and survivors, which also increases workload in other parts of the Department, including the Board of Veterans' Appeals and the Office of the General Counsel.

The Veterans Claims Assistance Act of 2000 has significantly increased both the length and complexity of claims development. VA's notification and development duties have grown, adding more steps to the claims process and lengthening the time

it takes to develop and decide a claim. Also, the Department is now required to review the claims at more points in the adjudication process.

VA will address its ever-growing workload challenges in several ways. For example, we will enhance our use of information technology tools to improve claims processing. In particular, our claims processors will have greater on-line access to DOD medical information as more categories of DOD's electronic records are made available through the Compensation and Pension Records Interchange project. We will also strengthen our investment in Virtual VA, which will reduce our reliance upon paper-based claims folders and enable accessing and transferring electronic images and data through a Web-based application. Virtual VA will also dramatically increase the security and privacy of veteran data. The Department will continue to move work among regional offices in order to maximize our resources and enhance our performance. Also, this year we will complete the consolidation of original pension claims processing to three pension maintenance centers which will relieve regional offices of their remaining pension work. In addition, we will further advance staff training and other efforts to improve the consistency and quality of claims processing across regional offices.

Using resources available in 2008, we are aggressively hiring additional staff. By the beginning of 2009, we expect to complete a 2-year effort to hire about 3,100 new staff. This increase in staffing is the centerpiece of our strategy to achieve our 145-day goal for processing compensation and pension claims in 2009. This represents a 38-day improvement (or 21 percent) in processing timeliness from 2007 and a 24-day (or 14 percent) reduction in the amount of time required to process claims this year.

In addition, we anticipate that our pending inventory of disability claims will fall to about 298,000 by the end of 2009, a reduction of more than 94,000 (or 24 percent) from the pending count at the close of 2007. At the same time we are improving timeliness, we will also increase the accuracy of the compensation claims we adjudicate, from 88 percent in 2007 to 92 percent in 2009.

Education and Vocational Rehabilitation and Employment Performance

With the resources provided in the President's 2009 budget request, key program performance will improve in both the education and vocational rehabilitation and employment programs. The timeliness of processing original education claims will improve by 13 days during the next 2 years, falling from 32 days in 2007 to 19 days in 2009. During this period, the average time it takes to process supplemental claims will improve from 13 days to just 10 days. These performance improvements will be achieved despite an increase in workload. The number of education claims we expect to receive will reach about 1,668,000 in 2009, or 9 percent higher than last year. In addition, the rehabilitation rate for the vocational rehabilitation and employment program will climb to 76 percent in 2009, a gain of 3 percentage points over the 2007 performance level. The number of program participants is projected to rise to 91,700 in 2009, or 5 percent higher than the number of participants in 2007.

Funding for Initiatives

Our 2009 request includes $10.8 million for initiatives to improve performance and operational processes throughout VBA. Of this total, $8.7 million will be used for a comprehensive training package covering almost all of our benefits programs. A little over one-half of the resources for this training initiative will be devoted to compensation and pension staff while nearly one-quarter of the training funds will be for staff in the vocational rehabilitation and employment program. These training programs include extensive instruction for new employees as well as additional training to raise the skill level of existing staff. Our robust training program is a vital component of our ongoing effort to improve the quality and consistency of our claims processing decisions and will enable us to be more flexible and responsive to changing workload demands.

NATIONAL CEMETERY ADMINISTRATION

Results from the December 2007 ACSI survey conducted by the National Quality Research Center at the University of Michigan and the Federal Consulting Group revealed that for the second consecutive time VA's national cemetery system received the highest rating in customer satisfaction for any Federal agency or private sector corporation surveyed. The Department's cemetery system earned a customer satisfaction rating of 95 out of a possible 100 points. These results highlight that VA's cemetery system is a model of excellence in providing timely, accessible, and high-quality services to veterans and their families.

The President's 2009 budget request for VA includes $181 million in operations and maintenance funding for the National Cemetery Administration (NCA), which is 71 percent above the resources available to the Department's burial program when the President took office. The resources requested for 2009 will allow us to meet the growing workload at existing cemeteries by increasing staffing and funding for contract maintenance, supplies, and equipment, open new national cemeteries, and maintain our cemeteries as national shrines. We will perform 111,000 interments in 2009, or 11 percent more than in 2007. The number of developed acres (7,990) that must be maintained in 2009 will be 8 percent greater than in 2007.

Our budget request includes an additional $5 million to continue daily operations and to begin interment operations at six new national cemeteries—Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Sarasota, Florida; and southeastern Pennsylvania. Establishment of these six new national cemeteries is directed by the National Cemetery Expansion Act of 2003. We plan to open fast track burial sections at five of the six new cemeteries in late 2008 or early 2009, with the opening of the cemetery in southeastern Pennsylvania to follow in mid-2009.

The President's resource request for VA provides $9.1 million in cemetery operations and maintenance funding to address gravesite renovations as well as headstone and marker realignment. When combined with another $7.5 million in minor construction, VA is requesting a total of $16.6 million in 2009 to improve the appearance of our national cemeteries which will help us maintain cemeteries as shrines dedicated to preserving our Nation's history and honoring veterans' service and sacrifice.

With the resources requested to support NCA activities, we will expand access to our burial program by increasing the percent of veterans served by a burial option within 75 miles of their residence to 88 percent in 2009, which is 4.6 percentage points above our performance level at the close of 2007. In addition, we will continue to increase the percent of respondents who rate the quality of service provided by national cemeteries as excellent to 98 percent in 2009, or 4 percentage points higher than the level of performance we reached last year.

CAPITAL PROGRAMS (CONSTRUCTION AND GRANTS TO STATES)

The President's 2009 budget request includes just over $1 billion in capital funding for VA, $5 million of which will be derived from the sale of assets. Our request for appropriated funds includes $581.6 million for major construction projects, $329.4 million for minor construction, $85 million in grants for the construction of State extended care facilities, and $32 million in grants for the construction of State veterans cemeteries.

The 2009 request for construction funding for our health care programs is $750.0 million—$476.6 million for major construction and $273.4 million for minor construction. All of these resources will be devoted to continuation of the Capital Asset Realignment for Enhanced Services (CARES) program. CARES will renovate and modernize VA's health care infrastructure, provide greater access to high-quality care for more veterans, closer to where they live, and help resolve patient safety issues. Some of the construction funds in 2009 will be used to expand our polytrauma system of care for veterans and active duty personnel with lasting disabilities due to polytrauma and TBI. This system of care provides the highest quality of medical, rehabilitation, and support services.

Within our request for major construction are resources to continue five medical facility projects already underway:

—Denver, Colorado ($20.0 million)—replacement medical center near the University of Colorado Fitzsimons campus

—Lee County, Florida ($111.4 million)—new building for an ambulatory surgery/outpatient diagnostic support center

—Orlando, Florida ($120.0 million)—new medical center consisting of a hospital, medical clinic, nursing home, domiciliary, and full support services

—San Juan, Puerto Rico ($64.4 million)—seismic corrections to the main hospital building

—St. Louis, Missouri ($5.0 million)—medical facility improvements and cemetery expansion.

Major construction funding is also provided to begin three new medical facility projects:

—Bay Pines, Florida ($17.4 million)—inpatient and outpatient facility improvements

—Tampa, Florida ($21.1 million)—polytrauma expansion and bed tower upgrades

—Palo Alto, California ($38.3 million)—centers for ambulatory care and polytrauma rehabilitation center.

In addition, we are moving forward with plans to develop a fifth Polytrauma Rehabilitation Center in San Antonio, Texas with the $66 million in funding provided in the 2007 emergency supplemental.

Minor construction is an integral component of our overall capital program. In support of the medical care and medical research programs, minor construction funds permit VA to address space and functional changes to efficiently shift treatment of patients from hospital-based to outpatient care settings; realign critical services; improve management of space, including vacant and underutilized space; improve facility conditions; and undertake other actions critical to CARES implementation. Further, minor construction resources will be used to comply with the energy efficiency and sustainability design requirements mandated by the President.

We are requesting $130.0 million in construction funding to support the Department's burial program—$105.0 million for major construction and $25.0 million for minor construction. Within the funding we are requesting for major construction are resources for gravesite expansion and cemetery improvement projects at three national cemeteries—New York (Calverton, $29.0 million); Massachusetts ($20.5 million); and Puerto Rico ($33.9 million).

VA is requesting $5 million for a new land acquisition line item in the major construction account. These funds will be used to purchase land as it becomes available in order to quickly take advantage of opportunities to ensure the continuation of a national cemetery presence in areas currently being served. All land purchased from this account will be contiguous to an existing national cemetery, within an existing service area, or in a location that will serve the same veteran population center.

INFORMATION TECHNOLOGY

The President's 2009 budget provides more than $2.4 billion for the Department's IT program. This is $389 million, or 19 percent above our 2008 budget, and reflects the realignment of all IT operations and functions under the management control of the Chief Information Officer.

IT is critical to the timely, accessible delivery of high-quality benefits and services to veterans and their families. Our health care and benefits programs can only be successful when directly supported by a modern IT infrastructure and an aggressive program to develop improved IT systems that will meet new service delivery requirements. VA must modernize or replace existing systems that are no longer adequate in today's rapidly changing health care environment. It is vital that VA receives a significant infusion of new resources to implement the IT-related recommendations presented in the Dole-Shalala Commission report.

Within VA's total IT request of more than $2.4 billion, 70 percent (or $1.7 billion) will be for IT investment (non-payroll) costs while the remaining 30 percent (or $729 million) will go for payroll and administrative requirements. Of the $389 million increase we are seeking for IT, 86 percent will be devoted to IT investment. The overwhelming majority ($271 million) of the IT investment funds will support VA's medical care program, particularly VA's electronic health record system.

VA classifies its IT investment functions into two major categories—those that directly impact the delivery of benefits and services to veterans (i.e., veteran facing) and those that indirectly affect veterans through administrative and infrastructure support activities (i.e., internal facing). For 2009, our $1.7 billion request for IT investment is comprised of $1.3 billion in veteran facing activities and $418 million in internal facing IT functions. Within each of these two major categories, IT programs and initiatives are further differentiated between development functions and operations and maintenance activities.

The increase in this budget of 94 full-time equivalent staff will provide enhanced support in two critical areas—information protection and IT asset management. Additional positions are requested for information security: testing and deploying security measures; IT oversight and compliance; and privacy, underscoring our commitment to the protection of veteran and employee information. The increase in IT asset management positions will bring expertise to focus on three primary functions—inventory management, materiel coordination, and property accountability.

Our 2009 budget request contains $93 million in support of our cyber security program to continue our commitment to make VA the gold standard in data security within the Federal Government. We continue to take aggressive steps to ensure the safety of veterans' personal information, including training and educating our employees on the critical responsibility they have to protect personal and health information. We are progressing with the implementation of the Data Security—Assess-

ment and Strengthening of Controls Program established in May 2006. This program was established to provide focus to all activities related to data security.

As part of our continued operation and improvement of the Department's electronic health record system, VA is seeking $284 million in 2009 for development and implementation of the Veterans Health Information Systems and Technology Architecture (HealtheVet-VistA) program. This includes a health data repository, a patient scheduling system, and a reengineered pharmacy application. HealtheVet-VistA will equip our health care providers with the modern tools they need to improve safety and quality of care for veterans. The standardized health information from this system can be easily shared between facilities, making patients' electronic health records available to all those providing health care to veterans.

Until HealtheVet-VistA is operational, we need to maintain the VistA Legacy system. This system will remain operational as new applications are developed and implemented. This approach will mitigate transition and migration risks associated with the move to the new architecture. Our budget provides $99 million in 2009 for the VistA Legacy system.

In support of our benefits programs, we are requesting $23.8 million in 2009 for VETSNET. This will allow VA to complete the transition of compensation and pension payment processing off of the antiquated Benefits Delivery Network. This will enhance claims processing efficiency and accuracy, strengthen payment integrity and fraud prevention, and position VA to develop future claims processing efficiencies, such as our paperless claims processing strategy. To further our transition to paperless processing, we are seeking $17.4 million in 2009 for Virtual VA which will reduce our reliance on paper-based claims folders through expanded use of electronic images and data that can be accessed and transferred electronically through a Web-based platform.

We are requesting $42.5 million for the Financial and Logistics Integrated Technology Enterprise (FLITE) system. FLITE is being developed to address a long-standing internal control material weakness and will replace an outdated, non-compliant core accounting system that is no longer supported by industry. Our 2009 budget also includes $92.6 million for human resource management application investments, including the Human Resources Information System which will replace our current human resources and payroll system.

SUMMARY

Our 2009 budget request of nearly $93.7 billion will provide the resources necessary for VA to:

—provide timely, accessible, and high-quality health care to our highest priority patients—veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs;

—advance our collaborative efforts with DOD to ensure the continued provision of world-class health care and benefits to VA and DOD beneficiaries, including progress towards the development of secure, interoperable electronic medical record systems;

—improve the timeliness and accuracy of claims processing; and

—ensure the burial needs of veterans and their eligible family members are met and maintain veterans' cemeteries as national shrines.

I look forward to working with the members of this committee to continue the Department's tradition of providing timely, accessible, and high-quality benefits and services to those who have helped defend and preserve liberty and freedom around the world.

Senator JOHNSON. Thank you, Secretary Peake. Before we begin with questions, I suggest we limit the time to 7 minutes per member. After each member has had their opportunity to ask questions, we can determine whether a second round is necessary.

Mr. Secretary, the VA's fiscal 2009 budget request proposes to cut $38 million for medical and prosthetic research. Your testimony states that the VA will allocate $53 million on research into mental illness. I will note that this is a $9.3 million cut into this designated research area.

Why is the VA cutting funding for research in the areas such as mental health at a time when more and more vets are being diagnosed with complex mental health disorders?

Secretary PEAKE. Sir, we do appreciate the importance and emphasize the importance of continuing research in the area of mental health, particularly in PTSD, given the current situation.

We have—we also work with DOD and bring in other grants to help support our efforts. We have mental health system centers that are in place to study PTSD and mental health issues of our service men and women. Some of that is actually supported also by Dr. Kussman's operational dollars, some $440 million, supports some of the people that actually work in those centers.

So, I think with—given the fact that we have $252 million really designated for the specific OIF/OEF kind of related research and the ability to bring in other dollars will allow us to keep our emphasis on this very important problem.

Senator JOHNSON. South Dakota is home to many Native Americans. What is the VA doing to address the needs of Native American veterans who live on reservations which can be hundreds of miles from a VA medical facility? How does this fit into the VA's plan to better serve those vets who live in rural areas?

Secretary PEAKE. Sir, I think the point that some of our Native American veterans have been some of our under served veterans is real and as a matter of fact, in some of my first trips, we went to Walla Walla, Washington, and Billings, Montana, Helena, Montana, and some of the town hall meetings made some of these points.

We have already put a video teleconferencing link in Montana to try to prove that point as an access point for people being able to understand their benefits. We have just recently established a Native American Council that we are putting together within the VA. It will actually be chaired by a Native American who is one of our hospital directors but to bring all the various pieces of the VA together around these issues.

We are working on a new memorandum with the Indian Health Service to find better ways to do partnerships with them and so we also recognize the importance and this was highlighted when I spoke with one of the large Native American organizations recently, that we really have to be able to work with 57 different sovereign nations and we absolutely understand that and are looking to ways to be able to do that more effectively.

Senator JOHNSON. Mr. Secretary, the ban on new priority 8 veterans that's been growing in the system has been in place for 5 years. This year, our vets with no service-connected disability and an annual salary as low as $28,430 would not be able to enroll in this system.

Have you considered raising the threshold to allow more priority 8 vets in?

Secretary PEAKE. Sir, we have. We are looking at what the impact of that might be, depending on different threshold levels. We want to make sure that we are able to meet the standards for those who are highest-priority patients, those with service-connected disabilities, those with special needs and those with truly significant income problems.

It is more than just a money issue. It is the facilities issue and we have already talked about trying to work down our backlog so that we do have the capacity to meet the needs of those who are

currently enrolled and are users and so we want to make sure that we can meet that priority first, but we are studying, just as you say, sir, looking at the level of it.

Senator JOHNSON. What is the timeline on the decisionmaking process? How soon will we know one way or the other about Category 8?

Secretary PEAKE. Well, sir, I don't know exactly when we will have that analysis back. I would expect to be able to get it back this year and be able to then work through what the right level would be, if indeed we would raise it.

Senator JOHNSON. The construction of medical facilities is of paramount importance. The backlog of urgently needed projects is growing.

Why has the VA not budgeted adequately to accelerate the pace of construction?

Secretary PEAKE. Well, sir, we've—$1 billion for construction is not an insignificant amount, but we have also been working on using leases, finding other ways of partnership to try to help. We have also been putting money, you may notice, into the repair and maintenance to try to eat away at the backlog, to maintain some of our buildings that we do have.

It is—and we are trying to understand the best way to partner with our, as an example, our academic partners, as we were talking about in Denver, to try to find ways to get the most bang for the buck.

Senator JOHNSON. $1 billion is an impressive amount of money on the one hand, but on the other hand, when you have a war costing $10 to $12 billion a month, it is not so much.

Senator Allard.

Senator ALLARD. Thank you, Mr. Chairman. Again, I'd like to welcome the Secretary, and as we discussed just before we reconvened here, you had been to Denver this last week and so I'm curious to just hear what your impressions are, address the progress that you've seen, and how you would evaluate the project from what you saw on this weekend's briefing and tour there of the new site that was set up in Denver.

Secretary PEAKE. Well, sir, on Sunday, I met with Senator Salazar and Congressman Pomodor and we walked and went around the site. I think I would just say that I'm enthused and optimistic about the opportunity to really be able to make a cornerstone of our integrated health care system for that region.

We understand that it is not Denver standalone as we look to our planning and when you look at the synergy that we can have with that wonderful medical center that has developed out there on the old Fitzsimmons campus, I think we have tremendous opportunity.

In fact, we will have a meeting Monday with the leadership. We had a meeting with the leadership also this last Monday in Denver and then we'll have a meeting in Washington with the leadership to really hammer out our road ahead. The site is coming together.

There's an issue about the swimming pool, just a legislative correction that's going to be needed to be able to give us the site, and then the UPI building, that paper is coming to my desk this week. So, I think that will give us the area to do the work in, and then

we need to figure exactly what work to do and we will be putting that together this next week.

Senator ALLARD. Now there's been some speculation about some comments you made about redesign of the project. You're not talking about a total comprehensive redesign, are you? You're talking about looking at maybe adjustments to perhaps the current design to make sure that you have the most modern facility is the way I understand without a complete overhaul.

I wonder if you could kind of clarify that.

Secretary PEAKE. Well, sir, what I—I think what we are looking to do is ensure that we can meet the needs of the veterans with the light rail coming in to the site, to be able to make sure we have the right-sized ambulatory environment, to make sure that we have the best mix with the university of the bedded requirement and we will have a bedded requirement for some time.

So, we may be able to leverage the university, give them the opportunity to build their bed tower earlier as we become a part of that, while we then optimize that particular location for the ambulatory piece. It is a redesign but it is—we're at a stage where that's not going to be a major—a slowdown or a setback. As a matter of fact, it probably will speed things up potentially.

Senator ALLARD. I mean that's good news to see it speeding up, and I think there was concern that if the design was too radical, it would slow down the project, meaning we'd have to start all over.

Secretary PEAKE. Working with the university, they could probably get it up quicker than we could.

Senator ALLARD. Yes. Well, that's all good news. Now, in this year's budget, 2008 budget, there's a $168.3 million allocated for the project, and this year in the president's budget, they had $20 million was requested.

Now do you believe the amount is sufficient to keep the project on track for a spring 2013 opening?

Secretary PEAKE. Sir, I do. I think, part of it is when you get the money that you can spend. So, I think we've got enough money to be able to complete the acquisition of the land and get moving on the design. We will need more money obviously in the 2010 budget. This is a project that we're going to move along.

Senator ALLARD. We actually have another partner in this thing. We've got the Veterans Administration, plus the CU Medical School, but then there's the city and county of Aurora.

Secretary PEAKE. And I met with the mayor, Mayor Tauer, as well.

Senator ALLARD. And they very much want to see things move forward.

Secretary PEAKE. His vision with the light rail has been very—I mean that really adds to the value of our proposal.

Senator ALLARD. Yes, I would think so, and we've encouraged him and we've pushed for the light rail in that particular part of the city in order to provide a number of transportation alternatives to the veterans that might want to go the CU Medical Center, including the veterans hospital that we anticipate having close by.

Okay. Let me move on to the cemetery needs for the State of Colorado, and I think, Bill, Mr. Tuerk, you have been out to Colorado and kind of understand our needs. Logan Cemetery, I've been told,

is—and we've discussed this, I think, with representatives from the—if not you, at least representatives from the Veterans Administration, that it's been projected that by 2020, it's going to be full.

Mr. TUERK. That's correct, Senator. I visited the cemetery last week to get a real lay of the land on the area that had not yet been buried out and we figure that space will be depleted in about 2020.

Senator ALLARD. So you would agree with those estimates then, and I guess it's hard, you know. We have had a lot of retired veterans move into Colorado, particularly the Colorado Springs area. I think they've got the second highest population of retired—I shouldn't say veterans, retired military in the country and so there is concern about, you know, space, particularly in the Colorado Springs area because of the rapid growth of retirees.

They get stationed there and then they decide they like Colorado and they want to come back there and retire, and I guess it's kind of hard to anticipate just what the retired military and veterans population would be in Colorado, but you're fairly comfortable with the 2020?

Mr. TUERK. Well, Senator, let me say this. I'm comfortable that 2020, give or take a year, maybe two, is a good solid estimate, based on current burial rates and current capacity at Fort Logan.

I'm also confident that the cities of Denver and Colorado Springs will have an ongoing need for VA burial services after Fort Logan is filled, and this budget request specifically is designed to start addressing the need in cities like the Denver-Colorado Springs area by asking for a separate land acquisition line item, so that we may start now to plan for the transition from a cemetery like Fort Logan that's going to have to close. We can't expand Fort Logan, we're landlocked at this point.

We're asking for that funding for the purpose of starting the transition to the successor cemetery to be built in anticipation of the closing of Fort Logan.

Senator ALLARD. We're filling up, yes. Now, is that under the construction initiative? Is that the $5 million that's in the——

Mr. TUERK. That is correct, sir.

Senator ALLARD. Okay. And so I wanted you to speak to that but you've already pretty well spoke to it.

You're comfortable with that money there to meet your current needs as far as cemetery expansion? Do we need any more money there?

Mr. TUERK. Well, I don't know yet, Senator, to be honest, because we don't have the authority to go scout for land yet and I don't yet have a sense of what it might cost for the acres that we might need.

It seems to me the ideal location for the successor cemetery would be somewhere between Denver and Colorado Springs, somewhere on the I–25 corridor, and I'm advised that land there is not going to be inexpensive, but I——

Senator ALLARD. You've got that right.

Mr. TUERK [continuing]. Have not yet gotten a sense of the precise quantum of funding we'll need to acquire a property.

Senator ALLARD. Yes, and I think the other thing, too, is water, if you get an area that's too rural there, water could be a problem. Even if you don't get one, the whole area in Douglas County, that

would be the area between Colorado Springs and Denver, there is some water issues, and I think when you're shopping for land, I hope that you will pay attention to the utilities and availability of water because you plant a lot of grass and in a State like Colorado, it's semi-arid, you'll use a fair amount of water.

So, I would just caution you to be careful about where you go. Just don't—you have to look at the value of the land obviously but you need to look at the water availability and utility availability.

Mr. TUERK. We'll be very conscious of the factors, Senator.

Senator ALLARD. That's a rapidly growing county and at one time it was the fastest-growing county in the country and I think they're among the fastest now, but still there's a lot of growth in that area and I wouldn't expect that the land values in there would depreciate much, if at all.

Mr. TUERK. I understand.

Senator ALLARD. More inclined to go up. So, the sooner you can get those purchases kind of nailed in, I think it would be better, frankly, because I don't see it being cheaper with time.

Okay. I just wanted to make sure that on those two projects for Colorado, that we were moving forward. They're projects that I've worked hard with the previous Secretary and the Secretary before that Secretary and I support your mission. I think it's vital that we provide good care.

I'm pleased with what has happened in Colorado where we had the closing of one VA hospital down on the Arkansas River there and we replaced it with clinics and so those clinics now with electronic records, I see where there was some opposition. The patients aren't much happier because they're much more available on a local basis and they don't like that and then they get referred to a now central facility in Denver. We want that to be a good facility. So, the electronic records, I was very pleased to see what you're doing in the electronic records. It brings accountability, brings some uniformity and helps you, I think, manage and set up goals and objectives to be able to measure results.

So, I'm pleased with your direction in that and I commend you for it and I do think that at one time veterans were hesitant to go to veterans facilities. They're looking at it as top-of-the-line now and looking forward to getting medical services from the VA and I compliment you on your efforts.

Senator JOHNSON. Senator Landrieu.

Senator LANDRIEU. Thank you, Mr. Chairman. Thank you, Mr. Secretary, and I appreciate the testimony.

I just have three questions. One of the major projects that we have ongoing in Louisiana, and I'm sure you are familiar with it, is the Veterans Hospital that we lost in the storms, it will be 3 years this August, and I want to first commend your staff there and the staff of the Veterans Administration for the excellent job they did in terms of evacuation and response.

I don't think we lost a single patient. The team there performed magnificently, and given the stress on many of the other hospitals, public and private, the veterans team is really to be commended.

In that regard, as you know, we have already appropriated $625 million for the replacement of the medical center. There have been some plans laid out, of course, and to rebuild that center. There's

some questions—or hospital. There's some questions about its size and et cetera, but my question is do you—is the regional planning commission downtown site still the preferred location for the new medical center, to your knowledge?

Secretary PEAKE. Yes, ma'am, and it's across the street from the LSU complex that they're looking at.

We think we have made some breakthroughs here. There was some question about whether we're going to have to do a full environmental study or not and what our folks have been down—actually, Mr. Hutter has been down there working and we have—we're going to resign the MOU with the city to allow them to go ahead and get moving on the land acquisition.

We think we have good support now from the historic people which was up in the air and we've got a game plan for 2012 opportunity to open.

Senator LANDRIEU. Well, I appreciate that because that was my next question.

The chairman is well aware of the struggle that we are going through to try to streamline this recovery process and one of the maddening requirements because we're using the community development block grant as we thought, we've learned since then, but initially we thought might be the quickest way to get money to locals has become a difficult way because of the requirement of the national environmental protection review, not because that's a problem but because FEMA also requires it and so for every project being built in the gulf coast, it's not one environmental review but two.

It's costly, it's expensive, it's a waste of time and money. So, I'm very pleased to see that you all have found a way legally through getting one that would be accepted by both Federal agencies, and is that what you're testifying to today, Mr. Hutter? Could I ask you?

Mr. HUTTER. Yes, Senator. We had a very successful meeting, two actually, in the last month with not only the city but the State and our Federal partners in this regard to move forward with one focused study with respect to the NEPA requirements and one focused study with respect to the historic preservation requirements, and we are—I'm glad to report that we are arm in arm with our partners in that regard.

Senator LANDRIEU. And I just want to show the chairman. This is the study that's been completed. As you can see, it's quite lengthy. I have not read it but intend to skim it, but this is a study and I'd like to show the staff, it's already been done and to require another study that basically is going to do the same thing just because of the, you know, technical part of having to use community development block grant, I think, is unnecessary. So, I'm very happy that progress has been made.

My second question relates actually to blind veterans. It's something that I've decided to try to concentrate on for a variety of reasons. I understand that there are 52,000 blind veterans enrolled in the VA Blind Services.

Currently, according to DOD, there have been 1,169 combat eye trauma injuries evacuated from OIF and OEF operations and about

16 percent of all wounded evacuated have eye injuries, plus there's some other indications that we should focus on this.

Last year or January, Secretary Nicholson announced plans for a 3-year commitment to this continuum of care and I'm sure, Mr. Secretary, you're aware of this.

My question is, is the VA continuing this program? Can you provide an update about where we are in implementing this program to the visually impaired?

Secretary PEAKE. Yes, ma'am. We are continuing the program. I was just out at Hines looking at our new center and it's really spectacular.

In terms of the—we have the inpatient centers as well as the network that's reaching out to allow more ambulatory care which is kind of the direction we are going in generally to allow people to stay near their homes and be able to get the kind of care that they need.

I think we'll reach out and get more people actually availing themselves of our services rather than having to make them come to just the inpatient centers, but we have those programs still.

I was at our blind center at West Palm not too long ago and they had actually shortened down some of the time that people come and spend with us because it made it more available to them. So, I think we are—there have been about 58, I think, OIF/OEF folks admitted to our inpatient blind rehab programs, but as you point out, there are others with optical injuries that have the opportunity to come and see us. So, I think we are well prepared to continue that.

Senator LANDRIEU. You know, and all injuries are, you know, heart-wrenching, but the plight sometimes of these individuals who are otherwise relatively healthy but have just lost their sight, with the right kind of training and opportunities, can re-engage in a very significant way, either, you know, operating within the military or continuing to, you know, be very, very productive, and I'm happy that you said that we're trying to be creative with using outpatient services because you can see here on the map that the inhouse places are really one in Puerto Rico, Birmingham, Alabama, Georgia, Connecticut.

There are very few in the West, and although I don't represent a Western State, it does concern me that we really don't have enough sites in the Western part of the country, so we might want to think about that as we develop this network, and then most importantly and cost effectively, using some university-based centers that might be effective in sort of a partnership.

The reason I raise this, and I'll finish with this in a moment, is I helped to create such a center not for veterans but for Louisiana citizens, a combination of the National Conference of Blind with the University Tech in one of our cities in North Louisiana and it's become a real sort of model for rehabilitation of individuals.

So, I'm going to pursue that with you later, and my final question is, I was rereading the Critical Health Care Mission of Veterans Affairs, Mr. Chairman, and, of course, one of them is Health Care to Veterans, obviously, to educate and train health care professionals, to conduct medical research, but the fourth was interesting.

It says, "To serve as a back-up to DOD health system in war or in other emergencies and support to communities following domestic terrorist incidents and other major disasters."

And again based on the experience that Louisiana, Mississippi just went through with this, my question is, have you not requested a special line item to meet the directions of this fourth stated mission, and if so, where is it, and if not, what could we do to maybe plus up this particular aspect of your agency?

Secretary PEAKE. We have an Assistant Secretary for Emergency Preparedness and Operations. If you really think about it and you look at Dr. Kussman's integrated health system, we are forward deployed all across this country and so the day to day operations of those extraordinary facilities, as you described the work that went on down there in Louisiana, and I agree with you about the credit that is due to them for that extraordinary effort, is available really everywhere.

As a senior medical Army guy for Hurricane Andrew relief, I integrated with the VA Medical Center down there very early on because they had the infrastructure to support other things that we were bringing in. So, it is an extremely important part of our readiness, but I'm not sure that it is all captured in a single line item that is part of our day to day operations.

Senator LANDRIEU. Well, I'd like to pursue that with you. My time is up, but I do see that—and I know you've got many missions to accomplish and this is not, you know, your primary, but I think an important secondary mission to be models of, you know, top-level evacuation and disaster response and it's a culture within, of course, the military that I think could be very helpful to local communities and so your budget, I know, is very tight, but as a member of the Homeland Security Committee and now a veteran of this recovery effort myself, I look forward to working with you all to see what I can do to be helpful to that part of your mission because I think it's critical in the event that we have another major disaster or a major terrorist attack, note that the one we had in New York was quite major, but something that really displaces millions of people.

It gets to be very hairy, as you know, in what happens at home. So, I thank you very much and I'll wait for additional time for my second round of questions.

Senator JOHNSON. Senator Reed, thank you so much for substituting for me during recent months.

I now recognize Senator Reed.

Senator REED. Thanks very much, Mr. Chairman, and let me just tell you the most electrifying sight of recent days to me is to see you sitting in that chair and presiding. So, I want to thank you for being the chairman of this committee and for your participation. It was a pleasure to work with you, Mr. Chairman, as you were there, both inspirationally and very, very practically. Thank you so much, sir. Thank you.

General Peake, good to see you onboard, sir. You are probably the best qualified person in a long time for the position, combat veteran of Vietnam, a general officer, somebody who understands your department's missions in every dimension. So, thank you very much. Gentlemen, thank you all, too, for what you do.

We are all concerned and I think you will second this concern about the mental health of our soldiers. This is something that is becoming one of the signature injuries of these conflicts, both TBI and also mental health stress, and there are lots of reasons for it. We don't have to go into them.

But we have a particular problem in the VA system, I believe, because these veterans are qualified to some health benefits, but their spouses and their children are also subject to these stresses. Regular forces, uniformed forces, their dependents are eligible for mental health care. They're on bases typically. They can go to the clinics. They can get the support. That's not the case too often with the veterans populations you're dealing with and just a for instance, our National Guard troops deploy from Rhode Island. They're in the middle of the fight.

I just visited last January the 69th MP Company that are training the Iraqi Highway Patrol in Ramadi. Their families, their children, their spouses back home in Rhode Island, the only place they can go to in proximity is a VA system.

So, the bottom line question is, what are you trying to do to reach that population? Do you need authority? Do you need resources? What can you tell us, sir?

Secretary PEAKE. Sir, first of all, those soldiers that are in Iraq or Afghanistan or on active duty, their families do have TriCare. They do have that opportunity.

The real issue for us, and you hit on something that we're concerned about, is when they come back, get separated and they're not medically retired, you know, the Reserve is back, they can avail themselves for 5 years of our services. They can come in and we can see them for service-connected issues, even without having to go through the adjudication process, and we can give counseling to their family members if it's part of the counseling of the soldier, of the veteran, in many cases a reservist, and what we can't do is write a prescription legally. You know, you can do it on the side and then you're medically legally liable yourself.

So, there are some issues that we are interested in exploring about how to better take care of the family because, frankly, the health any more is not just about the veteran, it's veterancentric, so that means we need a healthy family around it, and we agree with you that's an issue that we need to deal with.

Senator REED. I would very much like to work with you, sir, because I think also you're right, because when I've talked—you have an excellent VA facility in Rhode Island. Mr. Ing is the director there and his staff, down to the men and women that clean the facility, are impressive and they've impressed me tremendously.

But sometimes they have to stretch a bit to make it when it comes to the family because of counseling the soldier. That's something else I think we should work on with them. I want to work with you on this. This, I think, is a critical issue going forward.

I'm going to change the subject slightly. You're undertaking a major development, the HealtheVet System Information Technology. Staff has gone through and they looked at your budget. It's not clear what the total cost is, not clear if you've got a scheduled deployment over time with costs associated, and so let me just say

do you have a total cost figure? Do you have a deployment schedule, something that we can look at?

Secretary PEAKE. Well, sir, we are working very vigorously right now to get that all laid out in a programmatic kind of Palm fashion here and, you know, we have got ballparks that, you know, we can—this is a very, very big project. It is one that is essential to our future.

As Senator Allard said, this medical record piece is more than—it's really just more than the medical record. It's really the whole system of care integrated and it will be—I think it will take us right now till 2018 probably to get it all done with maybe somewhere in the $10 billion range to be able to really effect it and so we're going to need to be able to come back to you with really good plans and good costing because I know that's a lot of money, but it is a very critical thing for our future.

Senator REED. Thank you, General, very much, and this is a topic, I think, related to the first line of treating these current veterans.

What we see and what you see, too, is that you've got a soldier or a marine or a sailor, Air Force man or woman who comes through the system, they're up at Walter Reed, they're discharged, they're separated, now they're back home, miles away from the VA center, you know. They've been briefed about their benefits, but for 18–20 or even 50-year-olds, they want to go home after an injury, the briefing is sort of not retained sometimes.

What are you doing to reach out to identify all these reservists and Guardsmen, tracking them down, making sure in good faith that they know what they deserve and they're consciously saying I don't need it?

Secretary PEAKE. Well, sir, you're right. You want to hit them at the teachable moment and that teachable moment may be after they've gone and so we do a number of things already. We reach out with letters and follow-up letters from both the Secretary and the VBA and those folks, but those sometimes wind up in File 13 just like lots of other things.

We are working hard with our vet centers to do outreach so that there's somebody physically. We are hiring additional OIF/OEF people to be a part of that outreach so they have somebody they can recognize and hook up with.

We are expanding our community-based outreach centers, 64 this year, 51 in the 2009 budget, and then the other thing that we are doing which will start in May is to reach out telephonically. You know, if you think about it, sir, there are a 1.5 million people deployed, about 800,000 have separated, about half of those are active, half of them are Reserve and Guard. About 300,000 have already touched us at the VHA health system.

When they come and they touch us, they get mental health screening, TBI screening, suicide kinds of screening, but that's 500,000 out there that haven't, and so we're going to be telephoning. We're setting up the call centers to try to make those contacts, to find out if they need case management. It's really refreshing the relationship that the VA has maybe at the time when it is the teachable moment. So, we are enabled now by the fact that for 5 years, we're able to see them because of the NDAA and we want

to make sure that they're aware of that. So, we're reaching out in a marketing connection and actually teaching and I think that that will go a long way to achieving what you're talking about.

Senator REED. And I presume you'll be prepared to brief us periodically about how successful and you're going to develop the metrics to——

Secretary PEAKE. Yes, sir.

Senator REED [continuing]. What percent of the population you're contacting?

Secretary PEAKE. Exactly.

Senator REED. Thank you, sir. Just a final question because my time is rapidly expiring.

You've mentioned that the extension from 2 to 5 years now for OEF/OIF veterans to come into the system virtually without any questions or qualifications, just come on in, that, together with the normal flow of patients.

Have you recast your projections about the number of patients who come to see you and are they reflected in the budgets that you're looking at, not just this year but going out 5 years?

Secretary PEAKE. Well, sir, it's reflected in the budget for this year. We're anticipating about 14 percent. We budgeted 21 percent. So, yes, I think we've got it covered for this year and we will assess ourselves and as we build our budget for next year, we will then try to accommodate for what we believe is a reasonable number.

Senator REED. Thank you, sir. One of the things that—and again, because of Chairman Johnson's insistence and also the effort of Senator Hutchison, who is the ranking member, and the whole—on a bipartisan basis, we have significantly increased resources. I suspect we're going to do it again.

My fear is 5 years from now, when the memories fade but the veterans are still here, we won't be as responsive. So, I would hope everything you do now points the way and lets us know that 5 years from now we're going to need this much money and more and I will appreciate that.

Secretary PEAKE. Thank you, sir. We do appreciate this window of interest.

Senator REED. Thank you very much, sir. Gentlemen, thank you.

Senator JOHNSON. Mr. Secretary, thank you for appearing before the subcommittee today.

We all look forward to working with you this year as the 2009 budget process moves forward.

ADDITIONAL COMMITTEE QUESTIONS

For the information of the subcommittee members, if you have questions for the record that you would like to submit, please do so by the close of business on April 15, 2008.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR TIM JOHNSON

Question. The fiscal year 2008 Milcon/VA bill provided additional funding which allowed the VA to raise the travel reimbursement rate. On February 1, 2008, the VA increased the rate to 28.5 cents per mile from 11 cents per mile. Additionally the bill directed the VA to study the feasibility of establishing a transportation pilot

program aimed at improving access to medical facilities. Veterans residing in rural areas have voiced serious concern over the ability to get transportation to medical facilities.

In South Dakota, the Rural Transit Authority is recognized by the Center for Medicare and Medicaid Services and the transit authority can bill them for travel expenses that they provide. In the VA's evaluation of transportation programs, have you considered implementing a similar program?

Answer. While VA does not have all the details about the arrangement between the Rural Transit Authority and the Centers for Medicare and Medicaid Services, VA's existing statutory authority (38 U.S.C. 111) does not authorize VA to recognize a transit entity to directly bill VA for services provided to veterans.

VA currently has authority to provide a mileage reimbursement benefit or fund special mode transport (when medically indicated) to certain eligible veterans, including those living in rural areas, when traveling to VA or VA authorized health care. Mileage reimbursement provides an offset for a veteran's necessary travel expenses, while VA's special mode authority (e.g. ambulance, wheelchair van) allows arrangement of medically required travel at VA expense.

In addition, most Veterans Health Administration (VHA) Veterans Integrated Service Networks (VISNs) have established travel networks that provide transportation to and from their facilities. While these do not guarantee transportation for all veterans, they have increased accessibility for many.

The Disabled American Veterans (DAV) Veteran Service Organization also provides transportation for veterans, including rural veterans in some areas who do not otherwise have means of travel. This volunteer system has increased accessibility to veteran health care.

Finally, in response to Executive Order 13330, Human Service Transportation, that established the Federal Interagency Transportation Coordinating Council on Access and Mobility (CCAM), VA has been working with the CCAM to enhance transportation services for veterans. In response to a 2006 policy issued by the CCAM on March 2, 2007, VHA issued Under Secretary for Health Information Letter (IL) 10–2007–006, Human Service Transportation Coordination. The purpose of the IL was to provide medical centers appropriate guidance for implementation of "Human Transportation Services Coordination."

The IL strongly recommended that each facility take the following steps to comply with Executive Order 13330:

—Evaluate transportation services offered within the facility.
—Participate in any coordinated transportation planning processes in the local community.
—Consider offering any excess capacity in VA transportation services to other Federal agencies under agreements that provide for reimbursement to VA.
—Consider the feasibility of using any excess capacity in the transportation service of another Federal agency under an agreement that provides for reimbursement to that agency.
—Consider informing veterans of the transportation services of other government agencies that might be available to them.

Question. Also, given skyrocketing gasoline costs, does the VA plan to raise the beneficiary travel reimbursement rate higher in fiscal year 2009?

Answer. In accordance with Title 38 USC Section 111(g)(1), which requires the Department to undertake an evaluation of mileage rates when GSA changes employee travel reimbursement rates, VA will continue to evaluate the reimbursement rate taking into consideration veterans travel costs, including the rising cost of gasoline, and resources available for delivery of health care benefits for all eligible veterans.

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

Question. The State of Hawaii and the U.S. territories in the Pacific region have a high number of veterans. This remote geographic location makes it difficult for these veterans to travel the great distances that may be required to treat their conditions or to address their needs. What kind of plan does VA have in mind to address the needs of veterans located in Hawaii and U.S. territories in the Pacific region in the next 5 years, and what is being done to implement some of these goals?

Answer. The VA Pacific Island Health Care System (VAPIHCS) was established to meet the needs of veterans located in Hawaii and U.S. territories in the Pacific region. The VAPIHCS is an integrated healthcare system consisting of Community Based outpatient Clinics, outreach clinics and other programs tailored to provide quality healthcare to veterans in outlying and rural areas.

VAPIHCS has six CBOCs located on Kauai, Maui, Hawaii (Hilo and Kona), Guam, and American Samoa. A VA physician visits the two VA outreach clinics located on Lanai monthly. Traveling providers also include affiliate faculty specialist physicians who travel to Hawaiian neighboring islands to provide face to face consultations. Veterans on Molokai have access to contracted providers for healthcare, including mental healthcare. VA expends approximately $3.5 million on veteran beneficiary travel related to their medical care referrals.

We also employ a range of service delivery methods administered at the local level to address rural and highly rural veterans' access to care. For example, VA's Telehealth program provides a variety of medical specialty consultations and mental health services to all VA CBOCs. VA has also increased CBOCs, mail-order pharmacy, My-HealtheVet, and specialty programs—such as Home Based Primary Care and Mental Health Intensive Care Management programs.

Question. Could you please provide an update regarding the VA's plan to achieve the Congressional mandate in section 1635 of the 2008 National Defense Authorization Act for developing and implementing a fully interoperable and capable electronic health record system by September 2009?

Answer. VA is working closely with DOD to implement the provisions of Section 1635 of the 2008 National Defense Authorization Act (NDAA). On April 29, 2008, VA and DOD delivered a joint NDAA Implementation plan to Congress (Implementation Plan). The Implementation Plan includes a detailed schedule for electronic health record (EHR) requirements development, acquisition and testing activities, and implementation milestones to achieve the interoperable EHR by September 2009.

The Implementation Plan provides that by September 2009, VA and DOD will have implemented improvements and enhancements to the currently planned and existing bidirectional exchange of viewable electronic health information. For example, VA and DOD providers already exchange electronic pharmacy data, allergy data, theater clinical data, provider notes, problem lists, and procedures. VA and DOD exchange also inpatient information, such as consultations and discharge summaries, where available, from key military treatment facilities such as Landstuhl Regional Medical Center, Pre- and Post-Deployment Health Assessments and Post-Deployment Health Reassessments. By the end of 2008, VA and DOD will add the capability to share more data, such as vital signs, history information and questionnaires.

To validate that existing and planned data exchanges are supporting essential capabilities, and to move beyond the planned 2008 data exchange, VA and DOD established a Joint Clinical Information Board (JCIB). The JCIB is a joint board of clinician experts and treating physicians that has been given the lead to define the requirements for the interoperable EHR. This work includes defining what information must be shared and how that information must be shared. The JCIB will close the gap between what we are now sharing in viewable format, and what we must share in viewable and other formats, such as computable to achieve full interoperable capability.

The JCIB has already defined and validated EHR requirements, and those requirements are now in coordination for approval. Upon approval of the JCIB's EHR requirements and funding, the Departments plan to proceed with acquisition and development activities, testing, and implementation of interoperable electronic health record capabilities. VA is confident that it will achieve the target of fully interoperable electronic health record capability with DOD by September 2009.

In addition to having formed the JCIB, on April 17, 2008, VA and DOD formed the Interagency Program Office (IPO) as required by the law. On that date, the Departments appointed an acting director from DOD and an acting deputy director from VA. The IPO will be responsible for coordinating management oversight of VA and DOD projects supporting an interoperable electronic health record.

Question. How does VA intend to provide effective case management to the thousands of veterans who have sustained serious wounds since September 11, 2001, with six Federal Recovery Coordinators in place? At this time, it appears the resources dedicated to addressing this issue does not come close to meeting the need.

Answer. VA has a fully integrated case management team approach to assist veterans with access to care and in applying for benefits. On October 30, 2007, VA and DOD signed a Memorandum of Understanding for the joint oversight of the Federal Recovery Coordination Program (FRCP). The FRCP provides an integrated patient centered approach to care management and access to severely wounded, ill and injured service members, families, and veterans.

Federal Recovery Coordinators (FRC) provide oversight, management, and implement the Federal Individualized Recovery Plan (FIRP). The FIRP describes the objectives and resources necessary to assist the severely wounded, ill and injured serv-

ice member, family, and veteran. This enables this group to achieve their life long needs and goals through the recovery, rehabilitation, and reintegration phases of care. In addition to the FRCP director and supervisor, VA has been actively recruiting for additional staff to join the FRCP. This effort has yielded the recruitment of an additional five FRC staff members who will be joining the program by mid June. The additional five FRCs will be located in the following locations: National Naval Medical Center, Balboa Naval Medical Center, Brooks Army Medical Center, Providence Rhode Island VA Medical Center, and Houston VA Medical Center. Unfortunately, due to personal reasons one existing FRC staff member located at Walter Reed Army Medical Center will be leaving the program the first of June; however, with the five additional staff members now joining the FRCP, a total staff of 10 FRCs will be in place by mid June.

Phase One of the FRCP, scheduled to be completed in May 2008, targeted those catastrophically wounded, ill or injured arriving from theatre to the military treatment facility (MTF). Phase Two, which will begin immediately after phase one is completed, will expand FRCP's scope to include those service members and veterans who were discharged from an MTF prior to January 2008.

In support of the second phase, as well as ongoing activities of the FRCP, VA is recruiting a registered nurse (RN) case reviewer. The RN case reviewer, located at VA Central Office, will conduct patient interviews to determine if the patient would benefit from an FRC or any other care management program.

VA is also advertising for three additional FRC positions, beyond the initial 10 FRCs, who will be located at VA Medical Centers to assist patients who have already been through the MTF and are now in the community. These individuals will in turn become part of the FRC staff and should be in place by July 2008. Contact with these patients will be via televised (V-tel) meetings, phone and eventually secure email.

While the FRCP provides for the severely wounded, ill and injured service members, families, and veterans, other VA employees are stationed at eleven of the major military treatment facilities receiving casualties from Iraq and Afghanistan. VA staff brief service members about VA benefits, including healthcare, disability compensation, vocational rehabilitation, and employment. VA registers these veterans into the VA system and begins the process for applying for service connected compensation benefits. Beginning these processes prior to discharge from military service helps eliminate any gaps in services or benefits. VA social workers and nurses facilitate the transfer of veterans from these major MTFs to the VA polytrauma center or medical center closest to their home of record, whichever is most appropriate for the specialized services their medical condition requires.

Additionally, each VA Medical Center has an OEF/OIF case management team in place. Members of the team include: a program manager, clinical case managers, VBA Veterans Service Representatives, and Transition Patient Advocates (TPA). The program manager, who is either a nurse or social worker, has overall administrative and clinical responsibility for the team. The program manager must ensure that all OEF/OIF veterans are screened for case management. Severely injured OEF/OIF veterans are provided with a case manager and any other OEF/OIF veteran screened may be assigned a case manager upon request. Clinical case managers, who are either nurses or social workers, coordinate patient care activities and ensure that all VHA clinicians providing care to the patient are doing so in a cohesive and integrated manner. VBA team members assist veterans by educating them about VA benefits and assisting with the benefit application process. The TPAs serve as liaisons between the VISN, the VA Medical Centers, VBA and the patients. As the liaison, the TPA acts as a communicator, facilitator and problem solver.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. Secretary Peake, earlier this week the AP reported on $2.6 billion in credit card charges by VA employees. Most of the charges were routine, but as you know, some charges raised red flags among government auditors. I understand that the VA Inspector General and the GAO are now investigating the charges, but this report raises serious questions about spending controls at the VA.

Can you share with the committee what you know about the charges and what you are doing to prevent any similar problems from happening in the future?

Answer. During November 2007, VA provided the Associated Press (AP) with a summary of the purchases made with VA purchase cards in response to their Freedom of Information Act request. The data included the amounts of the purchases and merchant/vendor information. It did not include specific details about each purchase. The AP reported VA employees spent specific amounts at certain merchants

which were deemed questionable, but because the AP did not have specific purchase details, their implications of inappropriate use were not based on fact.

What's noteworthy is the AP reported the purchase card data provided revealed "few outward signs of questionable spending, with hundreds of purchases at prosthetic, orthopedic and other medical supply stores."

The AP reported purchases were made at casinos and luxury hotels in Las Vegas. VA, like many public and private groups, hosts conferences and meetings in Las Vegas due to the ease of participant travel, the capacity of the facilities, and the overall cost associated with hosting a large conference. Our investigation of the purchases made at these locations has shown that all charges were related to securing conference and meeting room space. The AP reported VA employees were using the card at casinos and luxury hotels and gave the false impression that VA employees used the card for personal use and or gain, which is not the case.

The AP also reported the card was used at movie theaters. Once again, this report creates a false impression. The Veterans Health Administration participates in various forms of outpatient recreational therapy for patients. Hosting supervised outpatient therapy treatments in a controlled setting such as a movie theater is often used to provide patients with an opportunity to spend a small amount of time away from a hospital setting, socializing them in the community, as they progress in their care. Card usage for such events is appropriate. In this case, the AP reported erroneous conclusions about particular purchases and created the false impression of misconduct. However, if we do find evidence of fraud, waste, or abuse in a program such as this, appropriate disciplinary action will be taken.

With respect to what VA is doing to prevent misuse of these cards, internal controls are established to prevent such misuse. VA has recently developed online training for cardholders and requires that cardholders and approving officials complete the training. This new training platform allows VA to monitor completion of training nationally and at the facility level via electronic reports, rather than file folders of training certificates. The platform is automatically set to require cardholders and approving officials to take refresher training every 2 years. Cardholders who do not complete the training within the allotted timeframe will have their cards cancelled.

Also cardholders are required to reconcile their accounts monthly and each cardholder has an approving official, typically the supervisor. The approving official is responsible for reviewing the purchases made by the cardholder, approving them for payment and ensuring cardholders are held responsible for inappropriate charges.

Since the release of the 2004 Inspector General and Government Accountability Office (GAO) reports, VA has focused on actively monitoring the more than 4 million annual purchase card transactions totaling over $2 billion. VA currently performs three audit processes in the review of purchase card transactions: a random audit of all transactions (selection criteria provides a 95 percent confidence level), a quarterly data mining audit, and on-site facility reviews.

During the quarterly process, all transactions are tested against specific rules in an effort to identify fraud, waste, and abuse. The transactions identified in this process are sent to the facility responsible for the purchase. The facility is required to provide supporting documentation. Less than 0.0008 percent of total transactions show potential fraud, waste, or abuse. Of these, the majority involved compromised card numbers. These are reported immediately and active measures are put in place to prevent future reoccurrence.

These audit processes also identify VA employee missteps. Annually about 0.002 percent of the 4 million transactions, or about $300,000 in purchases, involve procedural missteps usually where a cardholder exceeded his or her warrant or limit. These actions are ratified or corrected by local facility management, usually within 30 days. Since 2004, the number of these procedural missteps has significantly decreased from 419 to 95.

GAO conducted a forensic audit of government charge card programs at the request of the U.S. Senate Permanent Subcommittee on Investigations, Committee on Governmental Affairs. The auditors selected transactions randomly and used data mining techniques to identify questionable transactions. VA responded to multiple inquiries from December 2006 through April 2007.

The majority of the transactions were for equipment purchases; however, transactions for hotels, training, services, and awards were also selected. In the recently released report from GAO pertaining to this audit, VA was not specifically identified as being noncompliant with current regulations. More than 50 transactions were researched with a total dollar value in excess of $300,000. In conclusion, the vast majority of VA employees have a demonstrative record of appropriate purchase card use.

Question. Secretary Peake, at the Senate Veterans' Affairs Committee hearing in February, you said that you were willing to work with the committee to consider modifying the policy, adopted in 2003, that prohibits middle-income veterans, also known as Priority 8 veterans, from enrolling in the VA health care system. I understand that the VA is now developing actuarial modeling and will soon be conducting in-depth analysis to assess the timeline needed to build capacity for such a policy change.

Can you share with the committee where those studies stand and when they will be complete?

Answer. VA recently conducted an in-depth study to evaluate the impacts on the VA health care system under current enrollment policy and full enrollment entitled Analysis of the Requirements to Reopen Enrollment of Priority 8 Veterans. The analysis identified significant challenges with regard to building capacity, both in terms of infrastructure and staffing, required to reopen enrollment to Priority 8 veterans in the near term without severely disrupting VA's ability to provide timely, high quality care to currently eligible veterans.

Demand for VA health care services is projected to continue to grow under the current enrollment policy due to new enrollment of veterans in Priorities 1 through 7 and the aging of the enrolled population. While VA expects to virtually eliminate waiting lists by the end of next year, we need to continue to build capacity to meet the projected growth in demand for health care from currently eligible veterans

Currently, VA is developing actuarial estimates to assess the impact of reopening enrollment based on various income levels above the current VA Means Test and Geographic Means Test thresholds.

Question. Secretary Peake, as you know, it is projected that the number of female veterans who use the VA system will double in the next 5 years, assuming current enrollment rates stay the same, making female veterans one of the fastest growing subgroups of veterans. Last week, I introduced legislation with Senator Hutchison and other members to help the VA better care for the growing number of women veterans who will be entering the VA system.

Have you had a chance to review our bill—the Women Veterans Healthcare Improvement Act of 2008 (S.2799)—and if so, do you have a position on it?

Answer. VA provided its views on S.2799, the Women Veterans Health Care Improvement Act of 2008, in testimony before the Senate Committee on Veterans' Affairs on May 21, 2008. This testimony also provides information about current efforts by VA to respond to the needs of women veterans. An excerpt from the testimony is noted below. On May 2, VA began reaching out to nearly 570,000 combat veterans of the Global War on Terror to ensure they know about VA medical services and other benefits. The Department will reach out and touch every veteran of the war to let them know it is here for them. This is an example of VA acting proactively, and it enhances our ability to make women veterans aware of the many services and benefits VA provides.

EXCERPT FROM MAY 21, 2008 SENATE COMMITTEE ON VETERANS' AFFAIRS

In general, title I of S. 2799 would require VA to conduct a number of studies related to health care benefits for women veterans. Section 101 would require VA, in collaboration with VHA's War-Related Injury and Illness Study Centers, to contract for an epidemiologic cohort (longitudinal) study on the health consequences of combat service of women veterans who served in OEF/OIF. The study would need to include information on their general, mental, and reproductive health and mortality and include the provision of physical examinations and diagnostic testing to a representative sample of the cohort.

The bill would require VA to use a sufficiently large cohort of women veterans and require a minimum follow-up period of 10 years. The bill also would require VA to enter into arrangements with the Department of Defense (DOD) for purposes of carrying out this study. For its part, DOD would be required to provide VA with relevant health care data, including pre-deployment health and health risk assessments, and to provide VA access to the cohort while they are serving in the Armed Forces.

We do not support section 101. It is not needed. A longitudinal study is already underway. In 2007, VA initiated its own 10-year study, the "Longitudinal Epidemiologic Surveillance on the Mortality and Morbidity of OIF/OEF Veterans including Women Veterans." Several portions of the study mandated by section 101 are already incorporated into this project and planning for the actual conduct of the study is underway. The study has already been approved to include 12,000 women veterans. However, section 101 would require us to expand our study to include women active duty service members. We estimate the additional cost of including these in-

dividuals in the study sample to be $1 million each year and $3 million over a 10-year period.

Section 102 would require VA to conduct a comprehensive assessment of the barriers to the receipt of comprehensive VA health care faced by women veterans, particularly those experienced by veterans of OEF/OIF. The study would have to research the effects of 9 specified factors set forth in the bill that could prove to be barriers to access to care, such as the availability of child care and women veterans' perception of personal safety and comfort provided in VA facilities.

Neither do we support section 102. It is not necessary because a similar comprehensive study is already underway. VA contracted for a "National Survey of Women veterans in fiscal year 2007–2008," which is a structured survey based on a pilot survey conducted in VISN 21. This study is examining barriers to care (including access) and includes women veterans of all eras of service. Additionally, it includes women veterans who never used VA for their care and those who no longer continue to use VA for their health care needs. We estimate no additional costs for section 102 because VA's own comparable study is underway, with $975,000 in funding committed for fiscal years 2007 and 2008.

Section 103 would require VA to conduct, either directly or by contract, a comprehensive assessment of all VA programs intended to address the health of women veterans, including those related to PTSD, homelessness, substance abuse and mental health, and pregnancy care. As part of the study, the Secretary would have to determine whether the following programs are readily available and easily accessed by women veterans: health promotion programs, disease prevention programs, reproductive health programs, and such other programs the Secretary specifies. VA would also have to identify the frequency such services are provided; the demographics of the women veteran population seeking such services; the sites where the services are provided; and whether waiting lists, geographic distance, and other factors obstructed their receipt of any of these services.

In response to the comprehensive assessment, section 103 would further require VA to develop a program to improve the provision of health care services to women veterans and to project their future health care needs. In so doing, VA would have to identify the services available under each program at each VA medical center and the projected resource and staffing requirements needed to meet the projected workload demands.

Section 103 would require a very complex and costly study. While we maintain data on veteran populations receiving VA health care services that account for the types of clinical services offered by gender, VA's Strategic Health Care Group for Women Veterans already studies and uses available data and analyses to assess and project the needs of women veterans for the Under Secretary for Health. Furthermore, we lack current resources to carry out such a comprehensive study within the 18-month time-frame. We would therefore have to contract for such a study with an entity having, among other things, significant expertise in evaluating large health care systems. This is not to say that further assessment is not needed. We recognize there may well be gaps in services for women veterans, especially given that VA designed its clinics and services based on data when women comprised a much smaller percentage of those serving in the Armed Forces. However, the study required by section 103 would unacceptably divert significant funding from direct medical care. Section 103 would have a cost of $4,354,000 in fiscal year 2008.

Section 104 would require VA to contract with the Institute of Medicine (IOM) for a study on the health consequences of women veterans' service in OEF/OIF. The study would need to include a review and analysis of the relevant scientific literature to ascertain environmental and occupational exposure experienced by women who served on active duty in OEF/OIF. It would then have to address whether any associations exist between those environmental and occupational exposures and the women veterans' general health, mental health, or reproductive health.

We do not object to section 104. We suggest the language be modified to allow VA to decide which organization is best situated to carry out this study (taking into account the best contract bid). While IOM has done similar studies in the past, this provision would unnecessarily foreclose the possibility of using other organizations. We estimate the one-time cost of section 104 to be $1,250,000, which can be funded from existing resources.

Section 201 would authorize VA to furnish care to a newborn child of a woman veteran who is receiving VA maternity care for up to 30 days after the birth of the child in a VA facility or a facility under contract for the delivery services. We can support this provision with modifications. As drafted, the provision is too broadly worded. We believe this section should be modified so that it applies only to cases where a covered newborn requires neonatal care services immediately after delivery.

The bill language should also make clear that this authority would not extend to routine well-baby services.

We are currently unable to estimate the costs associated with section 201 without data on projected health care workload demands and future utilization requirements. We have contracted for that data and we will forward the estimated costs for this section as soon as they are available.

Section 202 would require the Secretary to establish a program for education, training, certification and continuing medical education for VA mental health professionals furnishing care and counseling services for military sexual trauma (MST). VA would also be required to determine the minimum qualifications necessary for mental health professionals certified under the program to provide evidence-based treatment. The provision would establish extremely detailed reporting requirements. VA would also have to establish education, training, certification, and staffing standards for VA health care facilities for full-time equivalent employees who are trained to provide MST services.

We do not support the training-related requirements of section 202 because they are duplicative of existing programs. In fiscal year 2007, VA funded a Military Sexual Trauma Support Team, whose mission is, in part, to enhance and expand MST-related training and education opportunities nationwide. VA also hosts an annual 4-day long training session for 30 clinicians in conjunction with the National Center for PTSD, which focuses on treatment of the after-effects of MST. VA also conducts training through monthly teleconferences that attract 130 to 170 attendees each month. VA has recently unveiled the MST Resource Homepage, a webpage that serves as a clearinghouse for MST-related resources such as patient education materials, sample power point trainings, provider educational opportunities, reports of MST screening rates by facility, and descriptions of VA policies and benefits related to MST. It also hosts discussion forums for providers. In addition, VA primary care providers screen their veteran-patients, particularly recently returning veterans, for MST, using a screening tool developed by the Department. We are currently revising our training program to further underscore the importance of effective screening by primary care providers who provide clinical care for MST within primary care settings.

We object strongly to the requirement for staffing standards. Staffing-related determinations must be made at the local level based on the identified needs of the facility's patient population, workload, staffing, and other capacity issues. Retaining this flexibility is essential to permit VA and individual facilities to respond to changing needs and available resources. Imposition of national staffing standards would be an utterly inefficient and ineffective way to manage a health care system that is dynamic and experiences continual changes in workload, utilization rates, etc.

Section 203 would require the Secretary to establish, through the National Center for PTSD, a similar education, training, and certification program for health care professionals providing evidence-based treatment of PTSD and other co-morbid conditions associated with MST to women veterans. It would require VA to provide these professionals with continuing medical education, regular competency evaluations, and mentoring.

VA does not support section 203 because it is duplicative of, and would divert resources from, activities already underway by the Department. VA is strongly committed to making state-of-the-art, evidence-based psychological treatments widely available to veterans and this is a key component of VA's Mental Health Strategic Plan. We are currently working to disseminate evidence-based psychotherapies for a variety of mental health conditions throughout our health care system. There are also two programs underway to provide clinical training to VA mental health staff in the delivery of certain therapies shown to be effective for PTSD, which are also recommended in the VA/DOD Clinical Practice Guidelines for PTSD. Each training program includes a component to train the professional who will train others in this area, to promote wider dissemination and sustainability over time.

Section 204 would require the Secretary, commencing not later than 6 months after the date of enactment, to carry out a 2-year pilot program, at no fewer than three VISN sites, to pay veterans the costs of child care they incur to travel to and from VA facilities for regular mental health services, intensive mental health services, or other intensive health care services specified by the Secretary. The provision is gender-neutral. Any veteran who is a child's primary caretaker and who is receiving covered health care services would be eligible to participate in the pilot program. VA does not support this provision. Although the inability to secure child care may be a barrier to access to care for some veterans, funding such care would divert those funds from direct patient care. We estimate the cost of section 204 to be $3 million.

Section 205 would require VA, not later than 6 months after the date of enactment, to conduct a pilot program to evaluate the feasibility of providing reintegration and readjustment services in a group retreat setting to women veterans recently separated from service after a prolonged deployment. Participation in the pilot would be at the election of the veteran. Services provided under the pilot would include, for instance, traditional VA readjustment counseling services, financial counseling, information on stress reduction, and information and counseling on conflict resolution.

VA has no objection to section 205; however, we are unclear as to the purpose of and need for the bill. We note the term "group retreat setting" is not defined. We would not interpret that term to include a VA medical facility, as we do not believe that would meet the intent of the bill. We also assume this term would not include Vet Centers as we could not limit Vet Center access to any one group of veterans. Moreover, many Vet Centers, such as the one in Alexandria, Virginia, are already well designed to meet the individual and group needs of women veterans. Section 205 would have no costs.

Section 206 would require the Secretary to ensure there is at least one full-time employee at each VA medical center serving as a women veterans program manager. We strongly support this provision. The position of the women veterans program manager has evolved from an overseer of local programs to ensure access to care for women veterans to a position requiring sophisticated management and administrative skills necessary to execute comprehensive planning for women's health issues and to ensure these veterans receive quality care as evidenced, in part, by performance measures and outcome measurements. The duties of this position will only continue to grow as we strive to expand services to women veterans. Thus, we believe there is support for the dedication of a full-time employee equivalent at every VA medical center. We estimate section 206 would result in additional costs of $7,131,975 for fiscal year 2010 and $86,025,382 over a 10-year period.

Next, section 207 would require the Department's Advisory Committee on Women Veterans, created by statute, to include women veterans who are recently separated veterans. It would also require the Department's Advisory Committee on Minority Veterans to include recently separated veterans who are minority group members. These requirements would apply to committee appointments made on or after the bill's enactment. We support section 207. Given the expanded role of women and minority veterans serving in the Armed Forces, the committees should address the needs of these cohorts in carrying out their reviews and making their recommendations to the Secretary. Having their perspective may help project both immediate and future needs.

Question. What VA is doing with regard to the increasing numbers of women veterans coming to the system and how is VA ensuring that their needs are being met?

Answer. In fiscal year 2007–08 VA funded a telephone-based survey of 3500 women veterans (both users and non-users of VA) to assess access to care, barriers to care and their specific healthcare needs. We have just completed an educational needs assessment of primary care providers and have planned a series of five "mini residencies" in fiscal year 2008, each training 40 providers, to update skills in women's health. We are also offering a national conference for primary care providers in summer, 2008.

In fiscal year 2007, women comprised 5.19 percent of all veteran users. However, the number of women using VA health care will continue to rise dramatically, and is projected to be 8.11 percent of all veteran users by fiscal year 2011. Since 2002, almost 39 percent of those women who have been deployed in OEF/OIF and discharged from active duty have enrolled in VA health care. We are very committed to not only addressing the current health needs of these returning women veterans but of keeping them healthy for life. We are creating new prevention programs directed to this young, relatively fit and healthy population.

The average age of all women seen by VA in fiscal year 2007 is 48.8 years old. This means that fully half of the women veterans seen in VA are of child-bearing age. Of the OEF/OIF women veterans, 86 percent are under age 40. This presents challenges for VA to address the reproductive health needs of our women veterans and to design and implement programs which address inadvertent exposure to medications which carry an increased risk of birth defects.

While we are focusing on our young returning women veterans, we are committed to not losing sight of the health needs of aging women veterans. We have addressed this population through:

—Cardiac risk intervention proposed initiative: American Heart Association Guidelines

—Cancer prevention proposed initiative: implementing tracking processes to address breast, cervical and colorectal cancer screenings in women

—Updating and improving our ongoing programs in gender specific care such as cervical cancer screening (pap Smears) and management of menopausal symptoms.

Question. Secretary Peake, when you were in front of the VA Committee in February, you mentioned that the average age of VA infrastructure is 57 years. All across the country there VA facilities in need of major repair. Yet, the President's budget cuts funding for major and minor construction programs by nearly 50 percent. In my home State of Washington, that means four major construction projects on the VA's priority list won't receive funding. In Seattle, I have two construction projects that are ranked at number 4 and number 5 on the fiscal year 2009 list that won't receive any funding. I also have important projects at the American Lake and Walla Walla VA Medical Centers that score well on this year's priority list, but do not receive funding under this budget.

Why is the administration cutting the VA construction budget by nearly half when, all across the country, VA facilities are in desperate need of repair?

Answer. VA deeply appreciates the support of Congress in providing funds for maintaining and improving its capital infrastructure. VA capital needs are evaluated, along with other Department needs on annual basis, and all funding decisions are reflected in the President's Budget submission. The Department is requesting $800 million for non-recurring maintenance projects which is a $227 million increase over what was originally requested in fiscal year 2008. This account is used to maintain and repair VA medical facilities. Additionally, as reflected in the fiscal year 2009 VA budget submission, (Construction and 5-Year Capital Plan, Volume 4—pages 7–200 and 7–201) there are currently 40 ongoing VA major medical facility projects. Congress has appropriated $3.7 billion to date for projects and other related medical major construction line items since fiscal year 2004.

Question. (VHA) DE Mr. Secretary, you recently sent me a response for the record to my earlier question stating that the VA has no intention of exercising the transfer authority we provided you for fiscal year 2008 that would assist the VA in building a training pipeline for psychologists skilled in treating PTSD, TBI and other post deployment issues. The Graduate Psychology Education Program at HHS has been up and running for 7 years and could easily be augmented to address VA concerns in setting up training sites.

With at least a third of returning Iraq and Afghanistan veterans suffering with mental health challenges, don't you think there is benefit—certainly there is available funding to find $5 million—for the VA to institute multiple approaches to building up a pipeline of specialists for the next several decades?

Answer. No—VA believes there would be limited benefits to increasing the pipeline of psychologists at the level proposed. Currently, there is an oversupply of psychology doctoral students relative to the number of available internship positions nationally. Each year, 20 percent or more students coming out of doctoral programs and seeking internships fail to match with an internship program because there is an oversupply of graduate students relative to the numbers of internship positions available. For the current year, 743 of 3492 applicants failed to match an internship position.

Instead of creating more doctoral students in psychology and enlarging the imbalance, VA believes that the pipeline would be better enhanced by creating additional internship positions. Through its Psychology Education Enhancement Initiative, VA in fact has committed an additional $5.3 million annually to increasing its psychology training positions nationally. About 60 of these are for Internship positions, while 100 are for Postdoctoral Fellowship positions.

It is not clear, as stated in the question, that augmenting the HHS Graduate Psychology Education program would facilitate VA training opportunities or the care of veteran patients. It is our understanding that the Graduate Psychology Education program does not have provisions for VA service commitments, through which graduates would be obligated to come to VA or to treat veteran patients.

Question. Secretary Peake, when Congress passed the Wounded Warrior bill as part of the of the Defense Authorization bill last year, we authorized the creation of three military centers of excellence—for TBI, PTSD, and Eye Trauma. The language of this Bill stated that these Centers would be a collaboration between the VA and the DOD, promoting the free exchange of information and ultimately benefitting our wounded warriors with these devastating injuries. The Pentagon is moving forward with Centers of Excellence for TBI and Mental Health. However, it is my understanding that the Pentagon is not going to establish the Military Eye Trauma Center called for in the Wounded Warrior bill, despite there having been approximately 1,400 combat eye wounded evacuated from Iraq and Afghanistan.

Can you tell me where things stand and why this has not been implemented?

Answer. VA and DOD are collaborating to develop the Center of Excellence in Eye Trauma pursuant to the National Defense Authorization Act. The Departments have held several planning meetings. One option under consideration is to use the existing TBI Center of Excellence as a model. The Center of Excellence in Eye Trauma is anticipated to be completed in fiscal year 2009.

Question. Once again, the President has proposed to send the money generated by the new veterans' healthcare user fees and increased co-pays directly to the Treasury. These new taxes on veterans have been rejected by Congress each and every year President Bush has proposed them. Yet, here we are again, having to fight the same old budget gimmick. Moreover, the President's proposed tax on veterans would be used to balance his budget—including to finance tax cuts for the wealthy.

Can you tell the veterans across the country why you think the President's proposed tax on them is necessary and should be used to balance the budget?

Answer. The 2009 budget contains three legislative proposals that ask veterans with comparatively greater means and no compensable service-connected disabilities to assume a modest share of the cost of their health care. The first proposal would assess Priority 7 and 8 veterans with an annual enrollment fee based on their family income:

Family Income	Annual Enrollment Fee
Under $50,000	[1]
$50,000—74,999	$250
$75,000—99,999	500
$100,000 and above	750

[1] None.

The second proposal would increase the pharmacy co-payment for Priority 7 and 8 veterans from $8 to $15 for a 30-day supply of drugs. And the third proposal would eliminate the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans.

The three proposals are consistent with the priority system of health care established by Congress, a system which recognizes that priority consideration must be given to veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs.

These proposals have no impact on the resources we are requesting for VA medical care as they do not reduce the discretionary medical care resources we are seeking. Our budget request includes the total funding needed for the Department to continue to provide veterans with timely, accessible, and high-quality medical services that set the national standard of excellence in the health care industry. Instead, these three provisions, if enacted, would generate an estimated $2.3 billion in revenue from 2009 through 2013 that would be deposited into a mandatory account in the Treasury.

Question. Dr. Peake, the administration's budget proposes a $4 million cut to the office of the VA Inspector General. As you know, the VA IG regularly conducts assessments at each and every VA health care facility across the country, and has played a constructive role in identifying issues relating to wait times, traumatic brain injury, and cases of waste, fraud and abuse.

At a time when the VA is taking on more responsibilities and an increasing workload, how does the administration justify a cut to the IG?

Answer. While the 2009 IG budget request does support fewer positions for the Office of Inspector General (OIG) in fiscal year 2009, the resource level is sufficient to meet its mandated obligations and to respond to the most urgent issues raised by Congress and the VA. OIG will continue to assess and prioritize its workload to maximize productivity and ensure the greatest impact possible. This level of funding will allow OIG to continue to address the challenges and growing demand for VA services.

Question. Secretary Peake, according to the Independent Budget for fiscal year 2009, in the past, population-based surveys have demonstrated that veterans report higher rates of alcohol abuse than nonveterans and are more likely to meet criteria for alcohol abuse and dependence. Recent studies have demonstrated no reduction in overall veteran need for substance abuse services and an increase in alcohol concerns by OEF/OIF veterans.

What should the VA be doing to address the increasing incidence of substance abuse problems?

Answer. VA is involved in a variety of initiatives to better address substance abuse. This includes enhancing substance abuse services integrated with primary care and as a component of general mental health services as well as substance abuse specialty services. Services in these three settings are necessary to address the needs of patients with distinct clinical profiles differing in terms of the severity of the substance use problem and the extent to which it coexists with other conditions.

To help recognize substance abuse problems, VA screens veterans in primary care and general mental health services at a minimum of once per year to identify patients who are consuming alcohol at hazardous levels. Patients who score positive on the screen are to be given an intervention immediately within primary care or, if the problem appears more severe than can be handled in this manner, the patient is to be referred to a specialty substance abuse clinic. Another important initiative is providing integrated care for substance use disorder treatment to patients who suffer co-occurring problems with substance abuse, e.g., integrated care for PTSD and substance abuse.

Question. Secretary Peake, I really appreciated the time that you took to visit the Walla Walla VA Medical Center in February. I think you gained a unique perspective on the issues affecting the 69,000 veterans who rely on that facility. As you can imagine, I stay in close contact with the veterans in the Walla Walla region. They continue to tell me how grateful they are for your support of a new residential rehab unit for mental health. Despite this, they remain very concerned about the stalled action on construction of a new outpatient clinic. I share that concern. As you know, the project is ranked 14th on the major construction list. But it will not receive any funding in this year's budget.

Will you pledge to work with me to make sure that the Walla Walla outpatient clinic receives design funding in next year's budget?

Answer. I assure you that the Multi-Speciality Clinic at Walla Walla will again be considered for funding in fiscal year 2010. If it is determined through the VA's established capital investment process, that the Walla Walla project is one of the Departments highest ranked projects, I pledge that I will work closely with you and other members of Congress to ensure that the design of this project (along with VA's other highest priority projects) is funded in fiscal year 2010.

Question. Secretary Peake, in February, the VA set up a temporary CBOC in Northwest Washington that is operating out of a van. As you may know, the permanent CBOC in Northwest Washington was supposed to be fully operational by February 2008.

Can you tell me when veterans in Northwest Washington can expect the permanent CBOC to be fully open?

Answer. On May 27, 2008 the mobile clinic in Northwest Washington moved to a 2,400 square foot interim building on the campus of the United General Hospital in Sedro-Woolley. Puget Sound expects to activate a permanent site in early fiscal year 2009.

QUESTIONS SUBMITTED BY SENATOR KAY BAILEY HUTCHISON

Question. Mr. Secretary, I would like to compliment the VA for its successes in the area of electronic health records. The VA is the leader in its use of electronic health records and is truly second to none, including the Department of Defense. However, these two agencies are not electronically sharing medical records as well or as fast as we had hoped. We all are working hard to see that our injured veterans receive world class care, and I think we all agree that in order for that to happen, veterans must move seamlessly from active duty in the Department of Defense to the Department of Veterans Affairs. We have discussed this a number of times but we still cannot completely transfer medical records between Departments and many records are still being lost between the time a soldier leaves the Department of Defense and arrives at the VA. Being a retired general officer, you know firsthand the challenges the VA faces in this area. My staff has asked for a separate detailed briefing on this project which I hope will answer many questions.

Mr. Secretary, please separate the Electronic Health Records project from the larger HealtheVet program and tell this committee when will this electronic health records project be finished, how much will it cost, and what is the schedule and cost for the larger program?

Answer. VA considers the pursuit of an electronic health record integral to nearly all of its healthcare operations and cumulative—it is a complete health record including all aspects of a patient's care. It is imperative to understand the electronic health record as a view of data that is generated as a by-product of conducting daily

healthcare operations. This method of collecting personal health information provides the best assurance of its timeliness, completeness, and accuracy. Because of this comprehensive scope, integral relationship to IT support for healthcare operations, and the close integration of the Electronic Health Record with HealtheVet, VA's budget data does not excerpt Electronic Health Record capability as a separate line item. It would be counter to the key design paradigm the VA is following described above to do so; both cost and schedule of electronic health record development mirror that of the transition to HealtheVet. Portions of the health record are already underway, and some will be complete as VA delivers portions of the VistA-HealtheVet Transition Plan as early as 2010. Final components are slated for later release, delivering in 2018. HealtheVet is currently estimated just over $10 billion for the full lifecycle, a significant portion of which is dedicated to the electronic health record. Already underway are extensive cost estimation and validation activities for the HealtheVet transition.

Will you tell us your perception as to why the VA and the DOD have not been able to bridge this electronic gap as soon as we had hoped, and what are you doing to address this problem?

Answer. VA and DOD have had significant success in sharing electronic health information that is available to be shared in enterprise-wide VA and DOD systems and for this reason, are successfully sharing the vast majority of information that is needed in the care and treatment of patients. For instance, our current bidirectional exchange makes almost all essential health information viewable, where that information is available from DOD's AHLTA system and legacy system, CHCS. Recent efforts have improved our ability to access available electronic inpatient information from DOD, as DOD has worked to standardize its implementation of an inpatient capability across major military treatment facilities.

Some DOD medical information was stored in paper format, or in stand alone DOD systems that did not interface with enterprise systems. In this instance, VA and DOD worked to together to ensure that necessary information was shared, even if not in electronic format.

VA and DOD are jointly developing an Information Interoperability Plan. The scope of this plan is to define a VA/DOD strategy for achieving the level of information interoperability essential to ensuring seamless continuity of care and benefits to our Nation's Armed Forces and Veterans. Specifically, the plan will:

—Define a strategic information interoperability maturation and organizing framework;
—Map the current and future essential health, personnel, and benefit information sharing;
—Identify capability gaps;
—Determine milestones to measure progress of near-, mid-, and long-term interoperability goals; and
—Leverage the national standardization activities led by the Department of Health and Human Services to foster health information sharing.

Question. Mr. Secretary, I would like to discuss another area of Information Technology. I understand that electronic health records are a way to provide better healthcare and claims service to our veterans and is your number one priority, but Congress has funded other VA programs, Financial Logistics Integrated Technology Enterprise (FLITE), for example, to modernize and integrate the VA's financial and healthcare systems. I would like to commend the staff of FLITE for creating the first and only VA IT program that has established a change management board, locked the program's scope, and set a clear timetable with recognizable milestones. This is a tremendous accomplishment. As we all have seen from failed IT projects at other Departments, the number one cause of the failure is the lack of defined requirements and management discipline. (The Census Bureau just announced losing a $3 billion project because they had 417 requirement changes after development began.)

I am interested to know VA's priority for FLITE and ask why VA reduced its budget and stretched the schedule out 12–18 months when this project is correcting a material weakness identified by several independent reports, and I'm told is doing exceedingly well?

Answer. VA had many difficult decisions to make regarding where IT funding would be allocated for fiscal year 2008 and fiscal year 2009. Our commitment to invest in veteran facing development initiatives coupled with needed resources to improve our infrastructure limited the funding for other high priority IT needs. The FLITE Program is a high priority in VA. Significant progress continues to be made developing both logistics and financial components of the program.

Question. Mr. Secretary, this subcommittee is committed to providing the veterans of Operation Enduring Freedom and Operating Iraqi Freedom with the best medical

care our Nation can provide. No one has ever questioned that. Many of our veterans are returning from these conflicts with wounds that transcend the medical traditions of compartmentalized care and require extremely specialized and more collaborative treatments. I know VA is working very well with many major medical and research universities to provide this specialized care.

From your experience as a doctor and Surgeon General, and now VA Secretary, please tell me what steps you are taking to fully rehabilitate these patients with combinations of traumatic brain injury, post-traumatic stress disorder, chronic pain and other highly specialized abnormalities by capitalizing on collaborative efforts with major medical and research universities.

Answer. As a result of new modes of injury (improvised explosive devices), improved body armor, and surgical stabilization at the frontline of combat, more soldiers are returning with complex, multiple injuries (polytrauma), including amputations, brain and spinal cord injuries, eye injuries, musculoskeletal injuries, vision and hearing loss, burns, nerve damage, infections, and emotional adjustment problems.

In response, VA's Office of Research and Development has expanded its efforts in polytrauma research and established a Polytrauma and Blast-Related Injury (PT/BRI) Quality Enhancement Research Initiative (QUERI) coordinating center to promote the successful rehabilitation, psychological adjustment, and community reintegration of these veterans. Two priorities have been identified: (1) traumatic brain injury (TBI) with polytrauma, and (2) traumatic amputation with polytrauma. The primary target is Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) VA patients, many of whom remain on active duty during their initial course of treatment in VA. However, these activities will benefit all VA patients with complex injuries, regardless of service era and mechanism of injury.

VA also recently issued a special solicitation for research projects on the long-term care and management, including family and community reintegration, of veterans with polytrauma, blast-related injuries, or TBI.

VA investigators are actively leveraging expertise in TBI and associated comorbidities including post-traumatic stress disorder, depression, substance abuse, and chronic pain, as well as in best practices for medically complex patients within the broader academic/scientific community. In addition to their VA roles, nearly all the principal investigators on these VA projects have affiliations at major medical and research universities including the University of Minnesota, University of Florida, Stanford University, Yale University and Virginia Commonwealth University, to name a few. In addition, experts from major universities and research institutions who do not hold VA appointments serve as co-investigators and consultants on many of these projects.

Question. Mr. Secretary, I understand the VA is experiencing a serious challenge to reduce the backlog of claims that have built up since 2000. I also understand that the number of claims has increased by roughly 50 percent since 2000—from 550,000 to 850,000—and that roughly one in four claims have eight or more disability issues, which increases complexity. Many of these claims have to be re-adjudicated several times, which has further slowed the processing time of new claims. Last year, the VA set its priority to reduce claims processing times to 160 days. Instead, the average waiting time has increased to 183 days. The claims backlog still stands at roughly 400,000 claims. As I have said to this subcommittee before, we do not want our veterans waiting any longer than necessary for the VA to process their claims. The Dole-Shalala commission recommended the VA reassess the overall process for claims and benefit processing.

Have you begun to reassess the overall claims and benefit processes to see if a complete process reengineering or methodology change may solve the problem?

Answer. The President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Commission) recommended that VA compensate veterans for lost quality of life due to disability in addition to its current statutory requirement to compensate veterans for average loss of earning capacity resulting from injury or disease incurred in or aggravated by service. In February 2008, VA contracted with Economic Systems Inc. to do two 6-month studies in response to the Dole/Shalala recommendations. One study is focused on transition benefits that would assist veterans and their families as they transition from military status to veteran status. The second study is focused on quality of life and earnings loss payments. The study is scheduled to be completed by early August 2008.

VA and DOD are jointly piloting a streamlined Disability Evaluation System (DES) process for service members being separated due to disability. Our stated goal is to be able to authorize any compensation to service members who are eligible on the date of separation from service. Although very early in the process, one service

member has completed the process and was awarded benefits on the date of separation.

VA is actively looking at consolidating the adjudication of claims for certain types of benefits to improve overall service delivery. This would include sending all pension claims to the Pension Maintenance Centers and sending all service-connected survivor benefit claims to centralized processing centers. We believe this specialization will improve service delivery of these benefits while freeing up additional resources to focus on disability claims.

Question. How do you plan to reduce this backlog and make electronic claims processing a priority for the VA in order to improve accuracy and reduce processing times? What can Congress do to assist you in these efforts?

Answer. The Veterans Benefits Administration (VBA) is aggressively pursuing measures to decrease the pending inventory of disability claims and shorten the time veterans must wait for decisions on their claims.

We are devoting additional resources to claims processing. Increasing staffing levels is essential to reducing the pending inventory and providing the level of service expected by the American people. We began aggressively hiring additional staff in fiscal year 2007, increasing our on-board strength by over 2,650 employees between January 2007 and April 2008. With a workforce that is sufficiently large and correctly balanced, VBA can successfully meet the needs of our veterans.

Because it requires an average of 2 or 3 years for our decision-makers to become fully productive, increased staffing levels do not produce immediate production improvements. Performance improvements from increased staffing are more evident in the second and third years. We have therefore also increased overtime funding this year and recruited retired claims processors to return to work as reemployed annuitants in order to increase decision output.

VBA, in collaboration with VA's Office of Information and Technology (OI&T), is developing the Paperless Delivery of Veterans Benefits Initiative. This initiative is envisioned to employ a variety of enhanced technologies to support end-to-end claims processing. In addition to imaging and computable data, we will also incorporate enhanced electronic workflow capabilities, enterprise content and correspondence management services, and integration with our modernized payment system, VETSNET. In addition, we are also exploring the utility of business rules engine software for both workflow management and to potentially support improved decision making by claims processing personnel.

The initiative builds on two pilot programs currently underway. These pilot projects have demonstrated the utility of imaging technology in our Compensation and Pension business line. Both projects utilize our Virtual VA imaging platform, which is a document and electronic claims-folder repository.

To fully develop this initiative, VBA will be engaging the services of a Lead Systems Integrator (LSI). The LSI will work closely with VBA and our OI&T partners to fully document business and system requirements. In addition, we will document demonstrable milestones and performance metrics, as well as life-cycle funding requirements. Ensuring a consistent funding stream to support this business transformation effort will be a critical success factor.

The recent Claims Processing Improvement study, conducted by IBM Global Business Systems, endorsed this strategy as a means to increase the efficiency of claims processing and enhance service delivery to our veterans.

Question. Mr. Secretary, as you know, we are all committed to ensuring that our soldiers returning from the War on Terror receive treatment for mental health problems as well as physical health needs. As more of our soldiers return home with Post Traumatic Stress Disorder (PTSD), this has become more of an issue. In 2006, Congress instructed the VA to establish three new Mental Health Centers of Excellence across the country to improve treatment, prevention, rehabilitation, and clinical services for our Nation's veterans. As I mentioned earlier you were kind enough to visit the center in Waco, Texas. I understand the VA has undertaken new initiatives to reduce the stigma associated with mental health disease and to reach out to more veterans and their families. I want to emphasize how important families are in the recovery of our wounded veterans.

What is the VA doing to expand access to mental health care for returning OIF/OEF veterans and their families, and tell us about the VA's attempts to reduce the stigma associated with mental health care?

Answer. The Mental Health Enhancement Initiative (MHEI) has expanded programs and access to mental health services in PTSD (e.g., outpatient PTSD capability in every VAMC and many CBOCS). Another component of MHEI has been to create Services for Returning Veterans-Mental Health teams; these are specifically created to provide rapid assessment and care for emotional/behavioral health issues of returning veterans.

Other MHEI expansions in mental health and substance use disorders also benefit OEF/OIF veterans. VA mental health is increasingly integrating mental health services in primary care venues through evidence based care management and collaborative care models. Receiving mental health care in the primary care setting is an especially effective way to reduce stigma and to communicate that mental health needs are an integral component of the overall health care needs of returning veterans.

Evidence Based Practices in exposure-based therapy of PTSD (the approach strongly endorsed by the recent Institute of Medicine report on PTSD treatment) are being disseminated across the system. The VA Office of Mental Health Services (OMHS) also has implemented a continuum of family services that includes family consultation, family education, and family psychoeducation for eligible veterans within existing statutory/regulatory authority. In providing this continuum, the OMHS has offered specialized evidence-based family psychoeducation training for clinicians.

The Mental Health Strategic Plan has initiatives to reduce the stigma associated with mental illness through partnership with other agencies and within VA. Many VA Medical Centers hold Recovery Celebrations that recognize veterans who have made significant strides towards their recovery. The VA also hires peer counselors as a way to reduce stigma.

Vet Centers provide mental health services to veterans and family members through a network of non-institutionalized community based Vet Centers. A majority of Vet Center staff are veterans themselves and understand the unique circumstances surrounding the veteran's readjustment to civilian life and its impact on his or her family. This helps to reduce the stigma associated with mental health care. Vet Centers provide typical mental health services such as individual and group counseling sessions. Since the beginning of the Global War on Terror, the Vet Center program has expanded from 206 Vet Centers in fiscal year 2003 to 232 Vet Centers by the end of fiscal year 2008.

Question. What training programs are the VA developing for the families of wounded soldiers to help them provide care once the service member returns home?

Answer. With regard to readjustment and mental health problems of returning veterans, the National Center for PTSD, in collaboration with the Department of Defense, has developed an excellent guide for families, titled Returning from the War Zone: A Guide for Families; this guide is available on the Web at http://www.ncptsd.va.gov/ncmain/veterans/. It covers important topics for families to understand during the readjustment process and when a veteran is having more significant mental health problems. It has frequent hits and downloads and we have received very positive feedback on it. The introduction gives a good sense of the content:

This guide is for services members and their families. It contains information to help military family members understand what to expect during the reintegration following time in a war zone, and to help them adapt back to home life with their loved one.

Reintegration is an adjustment for all involved. This information aims to make this process as smooth as possible and covers:

—A description of the common reactions that occur following deployment to a war zone

—How expectations about homecoming may not be the same for service members and family members

—Ways to talk and listen to one another in order to re-establish trust, closeness and openness

—Information about possible problems to watch out for

—How to offer and find assistance for your loved ones

—What help is available and what it involves . . .

In addition to the web-based guide, current best practices in mental health care emphasize intensive outpatient care, with the family involved in planning and implementing care and with the family receiving training on readjustment and handling mental health problems, along with the veteran. This helps send the message that recovery is possible and that the goals of treatment are to enhance the veteran's active roles in the community, family, workplace, etc. This recovery-oriented approach is greatly enhanced by family involvement during outpatient mental health care, and VA clinicians have been encouraged to emphasize this approach to the extent they can under current law. However, for those veterans who are not service-connected the current law only permits VA to provide counseling, training and mental health services to family members if those services were initiated during the veteran's hospitalization and the continued provision of these services on an outpatient basis is essential to permit the discharge of the veteran from the hospital.

In addition, current regulations generally do not allow VA to provide counseling, training, and mental health services to the family unless the veteran is enrolled and gives his or her permission for the family to be involved in the processes of diagnosis, treatment planning, and treatment implementation.

While Vet Centers do not provide training to assist family members in taking care of service members at home, they do provide family counseling and care-giver support as it relates to the readjustment of the veteran subject to the limitations for family members of nonservice-connected veterans noted above.

Question. Mr. Secretary, as you are aware, we had quite a revelation this week concerning the El Paso, Texas outpatient clinic being rated well below the national average by your own internal survey. As I mentioned in my letter to you yesterday I found this most disturbing and I want to be sure we work together to turn this around immediately. I am concerned that the veterans in the El Paso area are experiencing unusually long waiting times for specialty care appointments, particularly orthopedics and ophthalmology, and that their access to care in general is certainly not up to the standards we have come to expect from the Department of Veterans Affairs. After discussions with the VISN 18 Director it is my understanding that the Department is implementing a management plan to correct these issues to ensure that the veterans in the El Paso area receive the highest quality of health care this Nation can provide.

Mr. Secretary, would you please comment on the details of this management plan to correct the situation in El Paso and what I can do to assist you in these efforts?

Answer.

Wait times

The El Paso VA Health Care System (EPVAHCS) has improved the wait times for access to care in many areas. As the table below shows, EPCAHCS is currently seeing:

March 2008 data from VSSC	Percent seen within 30 days	Average patient wait time
Primary Care—New Patients	98.80	13.1
Primary Care—Established Patients	100.00	1.0
Ophthalmology—New Patients	88.20	22.3
Ophthalmology—Established Patients	97.70	1.9
Orthopedics—New Patients	98.20	12.9
Orthopedics—Established Patients	96.80	10.4

Management Plan

The Veterans Health Administration prepares a quarterly report with data on access, clinical care, and patient satisfaction at VA Medical Centers. Based on the fiscal year 2007 quarterly results for the EPVAHCS, a number of actions have been implemented to improve all aspects of quality, access, and patient satisfaction. This action plan includes five major areas of concern: access to care, customer service, telephone responsiveness, employee morale, and organizational health. The following summary provides the actions, goals, and timelines for continued improvement.

Access to care

—The EPVAHCS secured the assistance of a national consultation team in September 2007 to help their primary care staff work on improving access to care. For February 2008, 100 percent of EPVAHCS primary care patients were seen within 30 days. For specialty care, 97 percent were seen within 30 days.

—Facility leadership has asked the Advanced Clinic Access (ACA) National Consultation Team to return in July 2008 to assist with implementation of ACA in specialty care.

—EPVAHCS continues to move forward with an after hours clinic. In March 2008, pharmacy hours were extended to cover the later hours of operation. Due to concerns about the safety of patients, EPVAHCS has initiated discussions with William Beaumont Army Medical Center to jointly staff an urgent care center that will provide urgent care during both normal clinic hours and also evenings and weekends. It is anticipated that this process will be initiated by September 2008.

—*Customer Service.*—A customer service program has been initiated to educate staff about expectations for professional interactions with customers. EPVAHCS plans to have 75 percent of their staff educated about the customer service standards by June 2008 and 100 percent no later than September 2008.

EPVAHCS has a goal of achieving a 2 percent improvement in customer service scores by the end of the fiscal year and 5 percent improvement by the second quarter of fiscal year 2009.

—*Telephone Responsiveness.*—Telephone equipment was installed on February 28, 2008. Data from the new system became available in March 2008. As a result of the initial data, a decision was made to add staff to primary care, pharmacy, and the telephone operations units. A systems redesign team for telephone responsiveness was initiated to explore both the hardware and human factor issues related to the telephone system, and has a long term goal of answering all calls by the third ring.

—*Employee Morale.*—The national VA All Employee Survey data for the three most recent surveys shows that employees rated their overall satisfaction as 3.8, 3.7 and 3.7 (on a scale of 1 to 5); the results show that satisfaction is stable. This compares to the national satisfaction level of 3.77. EPVAHCS has worked with the National Center for Organizational Development (NCOD) to hold an annual management retreat, supplemented by quarterly retreats with front line staff, to engage employees at all levels of the organization in strategic planning and follow-up of ongoing improvement efforts.

—*Organizational Health.*—The management team has instituted several new processes in an effort to lead changes in staff interactions with veterans and each other. EPVAHCS has held several all employee meetings to discuss corporate expectations that both supervisors and staff adhere to national standards and expectations. NCOD is currently conducting a review of the organization's overall health.

Staffing Improvements

The following positions have been, or are in the process of, being filled:

—Nurse Practitioner, Primary Care, Las Cruces Community Based Outpatient Clinic (LCCBOC), filled April 28, 2008.

—Physician, LCCBOC, vacant since December 2007, still under recruitment. Temporarily filled with a locum tenens contractor since March 2008. Current contract extended through August 1, 2008.

—Nurse Practitioner, El Paso, filled effective May 8, 2008.

—Another Nurse Practitioner position, filled with a Physician, January 2008.

—Other Physician positions in the process of being filled at the El Paso site:

—Two physician positions filled March 2008; credentialing is in process.

—Physician position filled; start date May 27, 2008.

—Physician position filled; new employee has a private practice to shut down, therefore a starting date is pending.

—Physician position selected on May 9, 2008; credentialing is in process.

—There is ongoing recruitment for an additional two new Physician positions and a new Nurse Practitioner position at the El Paso site. Applications are currently being accepted.

—A second Orthopedic Surgeon in Specialty Care will start at the end of July or early August. This new physician will increase orthopedic services by 100 percent.

—Another Teleretinal Imager is being recruited. This will increase teleretinal imaging by 50 percent.

—In addition, two more optometrist positions have been approved and are in the process of recruitment.

—For all specialty care areas, El Paso has been referring patients who cannot be seen within 30 days to the private sector (when there are specialists available).

Question. Mr. Secretary, over the past several years, the VA has faced a heightened medical workload. I understand the challenges of working within fiscal constraints, but I am concerned that major construction projects for new hospitals and clinics are vital to expand the VA's health infrastructure and give our veterans the best health care this nation can provide. This has been an issue discussed many times on this subcommittee, but I particularly note this year's major construction request is roughly half of last year's appropriation.

Will you comment on the VA's long-term capital plan and how you see it evolving?

Answer. The main purpose of the VA 5-Year Capital Plan is to provide a systemic and comprehensive framework for the effective management of the Department's capital investments, the ultimate goal of which is to lead to improved health care and benefits (including burial services) delivery for our Nation's veterans. Although the overall goal of the plan will remain constant, the mode of attaining it will mostly likely change in the future.

The plan will continue to provide important information on the top construction priorities (existing and future) and the continued implementation of CARES deci-

sions. As also shown in the fiscal year 2009 budget submission, the future funding needs for these existing ongoing projects is currently $2.3 billon. Along with the existing projects, there are a number of known potential major medical facility projects which are also listed in the VA budget submission (Construction and Capital Plan, Volume 4—pages 7–86 through 7–89). The list of potential projects are updated each year as part of the annual VA capital investment process, and projects may be added or deleted from this list.

VA will also continue to work to better assist homeless veterans. The Department is currently performing a Site Review Initiative whose goal is, to decrease the amount of underutilized real property and maximize its value through VA's enhanced-use leasing program. VA would reinvest realized proceeds to enhance services to veterans.

In addition, future capital plans will continue to place increased emphasis on the utilization of renewable energy. The growing importance of physical security of VA infrastructure will also be reflected in future plans. VA will continue to strive to be a leader in these areas as well as ensuring we are caretakers to the environment.

QUESTIONS SUBMITTED BY SENATOR MITCH MCCONNELL

Question. In the context of the Department of Veterans Affairs, what Dole-Shalala Commission recommendations still require legislative remedies?

Answer. For each Dole-Shalala Commission recommendation, there are action steps that provide VA with guidance on how to implement a specific recommendation. The following action steps within a specific recommendation still require legislation.

RECOMMENDATION 2—COMPLETELY RESTRUCTURE THE DISABILITY AND COMPENSATION SYSTEMS

Action Step

Congress should clarify the objectives for DOD and VA disability systems, in line with this recommendation.

Status—Legislation Required

The administration submitted draft legislation to Congress on October 16, 2007, to address this recommendation.

Action Step

Congress should restructure VA disability payments to include:

—"transition payments"—to cover living expenses for disabled veterans and their families. They should receive either 3 months of base pay, if they are returning to their community and not participating in further rehabilitation OR longer-term payments to cover family living expenses, if they are participating in further rehabilitation or education and training programs.

—once transition payments end, disabled veterans should receive earnings-loss payments—to make up for any lower earning capacity remaining after training

—quality-of-life payments—to compensate for non-work-related effects of permanent physical and mental combat-related injuries

Status—Legislation Required

The administration submitted draft legislation to Congress on October 16, 2007, to address this recommendation. In order to be prepared for legislative changes consistent with this recommendation, VA contracted with Economic Systems, Inc. to conduct two studies. The results of both studies are to be reported in August 2008.

Action Step

To improve completion rates in its VRE program, VA should:

—pay a bonus (10 percent of annual transition pay) for completing first and second years of VRE training and 5 percent for completing the third year

Status—Legislation Required

The administration submitted draft legislation to Congress on October 16, 2007, to address this recommendation.

RECOMMENDATION 4—SIGNIFICANTLY STRENGTHEN SUPPORT FOR FAMILIES

Action Step

DOD and VA should provide families of service members who require long-term personal care with appropriate training and counseling to support them in their new care giving roles.

Status—Legislation Required

The administration submitted draft legislation to Congress on October 16, 2007 to address this recommendation.

Question. Could you please provide a status update on the community-based outpatient clinic slated for Owensboro, Kentucky?

Answer. Owensboro is a Marion VAMC CBOC and it is expected to open by the end of fiscal year 2008. The CBOC will provide primary care and mental health services.

Question. Could you please provide a status update on the community-based outpatient clinic slated for Grayson County, Kentucky?

Answer. Grayson County is a Louisville VAMC CBOC and it is expected to open by the end of fiscal year 2008. The CBOC will provide primary care and mental health services.

Question. Since I represent a State with a significant population of rural veterans, I am concerned about access to health care for veterans who live in remote areas. What is the Department doing to look after rural veterans in States such as Kentucky?

Answer. VHA has established the Office of Rural Health (ORH) to address the needs and challenges of providing healthcare to veterans in rural areas. The ORH collaborates with other VA program offices and leverages rural health expertise from the public and private sector, to identify service delivery gaps and assess multiple care delivery models to ensure those veterans in rural and highly rural locations have access to health care.

VHA employs a range of service delivery methods, administered at the local level, to address rural and highly rural veterans' access to care. Examples of these include expanded Telehealth services, increased CBOCs, mail-order pharmacy, MyHealtheVet, and specialty programs such as Home Based Primary Care and Mental Health Intensive Care Management.

The most recent ORH initiatives to increase access in rural areas included development of outreach clinics, which are part time outpatient clinics providing primary care and mental health care, and a pilot project to establish Mobile Health Clinics. Specific to Kentucky, VHA currently has 13 CBOCs opened in Kentucky, seven of which are located in rural areas:

—Prestonburg (Floyd County)
—Somerset (Pulaski County)
—Morehead (Rowan County)
—Bowling Green (Warren County)
—Fort Campbell (Christian County)
—Hanson (Hopkins County)
—Paducah (McCracken County)

An additional seven CBOCs have been approved. They will open before the end of fiscal year 2008, with one slated for early fiscal year 2009. All will be located in rural areas:

—Berea (Madison County)
—Hazard (Perry County)
—Leitchfield (Grayson County)
—Carollton (Carroll County)
—Hopkinsville (Christian County)
—Owensboro (Daviess County)
—Mayfield (Graves County)

Question. Does the Department of Veterans Affairs need any additional legislative authority to improve its delivery of health-care services to veterans, in particular, those suffering from post-traumatic stress disorder or traumatic brain injury?

Answer. We continuously evaluate the need to ensure that veterans, including those with post-traumatic stress disorder or traumatic brain injury, receive optimal care. The President's 2009 budget includes a proposal to expand legislative authority in title 38, United Stated Code, section 1720, to cover payment of Specialized Residential Care and Rehabilitation for OIF/OEF Traumatic Brain Injured (TBI) Veterans. This expansion of authority will permit VA payment for residential rehabilitation of TBI veterans with special needs through the Medical Foster Home component of VA's Community Residential Care Program. This legislation allows VA to develop comprehensive treatment programs for OIF/OEF TBI patients that can be located close to the patient's hometown. We look forward to working with Congress to enact this legislative proposal. The administration will send to Congress any additional legislative proposals as they are identified.

QUESTION SUBMITTED BY SENATOR ROBERT F. BENNETT

Question. Mr. Secretary, over the last several months the Department of Veterans Affairs has announced the establishment of a number of Vet Centers around the country. I have been provided a brief overview of the decision making process for determining the locations of these new Vet Centers, but many questions remain. Can you or your staff provide me with a more comprehensive explanation and also discuss considerations for future centers?

Answer. Vet Center site selection is based on an evidence-based analysis of demographic data from the U.S. Census Bureau, DOD Defense Manpower Data Center (DMDC), VetPop2007 (VA's latest official estimate and projection of the veteran population) and by input from the seven Readjustment Counseling Services regional offices.

The main criteria for new Vet Center site selection is the veteran population, area veteran market penetration by Vet Centers, geographical proximity to VA Medical Centers, and Community Based Outreach Clinics in the Vet Center's Veterans Service Area. This analysis includes information from the DMDC as to the current number of separated OEF/OIF veterans and the reported distribution of home zip codes of separated OEF/OIF veterans, as well as the number who were married and those with children. Special consideration for relatively under-served veterans residing in rural areas at a distance from other VA facilities is also reviewed. Proposals are developed and vetted through local and regional Vet Center leadership, and then submitted to the Under Secretary for Health for review and approval.

SUBCOMMITTEE RECESS

Senator JOHNSON. Again, thank you, Mr. Secretary, for your testimony.

This hearing is recessed.

[Whereupon, at 4:43 p.m., Thursday, April 10, the subcommittee was recessed, to reconvene subject to the call of the Chair.]